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JUVENILE DETENTION CENTERS: ARE THEY WAREHOUSING CHILDREN WITH MENTAL ILLNESS?

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

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WEDNESDAY, JULY 7, 2004

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:01 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Lautenberg, Carper, and Durbin.

OPENING STATEMENT OF CHAIRMAN COLLINS

Chairman COLLINS. The Committee will come to order.

Good morning. Last summer, the Committee on Governmental Affairs held a series of hearings to examine the difficult challenges faced by families with children with mental illness. We heard compelling testimony from families who described their personal struggles to get mental health services for their severely ill children. They told us about the limitations in both public and private insurance coverage, the shortage of mental health professionals, and the long waiting list for desperately needed mental health services.

They discussed the lack of coordination and communication among the various agencies and programs that serve children with mental health needs. And most disturbingly, they told us that some parents are actually advised that the only way to get the intensive care and services that their children need is to relinquish custody and place them in the child welfare or juvenile justice system. This is a wrenching decision that no family should ever have to make. No parent should have to give up custody of his or her child just to get the health care services that that child so desperately needs.

Today, we will be examining another consequence of our tattered safety net for children with mental illness, and that is the inappropriate use of juvenile detention centers as holding areas for people who are waiting for mental health services. Like custody relinquishment, these inappropriate detentions are a regrettable symptom of a much larger problem, which is the lack of available, affordable, and appropriate mental health services and support systems for these young people and their families in the communities in which they live.

Serious mental illness afflicts millions of our Nation's children and adolescents. It is estimated that as many as one in five American children under the age of 17 suffers from a mental, emotional,

or behavioral illness. What is even more disturbing is the fact that two-thirds of all young people who need mental health treatment are not getting it.

If two-thirds of children with cancer were not getting the treatment that they needed, there would be a huge public outcry. Yet we have a situation in this country where two-thirds of the children with serious mental illness are not getting the services that they need.

When a child has a serious physical health problem like diabetes or cancer, the family turns to their doctor. But when a family includes a child with a serious mental illness it is often forced to go to child welfare or the juvenile justice system to secure treatment. Yet neither system is intended to serve children with serious mental illness. Child welfare systems are designed to protect children who have been abused or neglected. Juvenile justice systems are designed to rehabilitate children who have committed criminal or delinquent acts. While neither of these systems is equipped to care for a child with a serious mental illness, in far too many cases there simply is nowhere else for the family to turn.

In extreme cases, families may feel forced to actually file charges against their child or to declare that they have abused or neglected them in order to get the care that they need. As one advocate observed, "beat them up, lock them up, or give them up" characterizes the choices that some families face in their efforts to get help for their children's mental illness. Those are clearly no choices at all.

According to a General Accounting Office study that I requested last year with Representatives Pete Stark and Patrick Kennedy, parents placed more than 12,700 children into the child welfare or juvenile justice systems in 2001 so that these children could receive mental health treatment. Of these 12,700 children, 9,000, the vast majority, entered the juvenile justice system.

I believe that this statistic represents just the tip of the iceberg since 32 States, including five with the largest populations of children, did not provide the GAO with any data. Other studies indicate that the problem is even more pervasive. A 1999 survey by the National Alliance for the Mentally Ill found that 36 percent of the families surveyed placed their children in the juvenile justice system to access mental health services that otherwise were not available to them.

The question is, what happens to these children when they are turned over to the juvenile justice system? Unfortunately, the report that Congressman Henry Waxman and I are releasing today shows that too often they are simply left to languish in juvenile detention centers which are ill-equipped to meet their needs while they wait for scarce mental health services.

A compelling series of stories by Barbara Walsh of the *Portland Press Herald* in Maine detailed the obstacles that many Maine families have faced in getting care for their children with mental illness. One of her stories was entitled, "Locked Up, Waiting for Help." It told the story of a clinically depressed 14-year-old boy who was held in limbo in the Cumberland County Jail while he waited for a bed in a residential treatment center. While he was supposed to be placed within a few weeks, he wound up sitting in a jail cell

for 4 months without any treatment. While he waited his illness grew worse. He was also locked up with many older, more violent kids, and was ultimately sexually assaulted. Later he attempted suicide.

Unfortunately, this sad story is not unique. The report we are releasing today demonstrates that this terrible problem exists nationwide. Based on a national survey of the juvenile detention center administrators, the report finds that the use of juvenile detention facilities to warehouse children with mental disorders is a serious national problem. Over the 6-month period covered by our report, nearly 15,000 incarcerated youth were detained solely because they were waiting for mental health services. Many were held without any charges pending against them, and the children who were incarcerated unnecessarily while waiting for treatment were as young as 7 years old.

Finally, the report estimates that juvenile detention facilities are spending an estimated $100 million of taxpayer's money each year simply to warehouse these children and teenagers while they are waiting for services. This morning's hearing will provide an opportunity for representatives of the juvenile justice and mental health systems, as well as advocates for children and their families, to respond to this report. My hope is that this hearing will not only heighten public awareness of the difficult problems confronting these children and their families but also help us to make the case, help us to press for legislative and administrative reforms at both the State and the Federal level to reduce the barriers to care for children who suffer from mental illness.

In closing, I want to commend Congressman Henry Waxman for his outstanding leadership on this issue. He has long been a leader on health care issues, and it has been a pleasure to work with him on this report. I am hoping that our bipartisan, bicameral efforts will produce real reform because it is desperately needed. I also want to salute the Congressman's staff for the excellent research that they did in compiling this report. The Congressman will be our leadoff witness, just as soon as I turn to Senator Lautenberg for his opening comments.

OPENING STATEMENT OF SENATOR LAUTENBERG

Senator LAUTENBERG. I thank you, Madam Chairman, for holding this hearing and for your statement which I think is very accurate and at the same time descriptive, especially in that cryptic comment about give them up, beat them up. What was that exactly?

Chairman COLLINS. Beat them up, lock them up, or give them up. It is awful.

Senator LAUTENBERG. Terrible. It conveys a sense of the desperation that families go through. I am pleased also, Madam Chairman, that we have Congressman Waxman here and that the two of you have worked together. I think that is excellent. Congressman Waxman and I have worked on many things together and I always find him especially circumspect about the things we do, and searching for accuracy in his presentations. And the outcome often points to the research having been so effective.

Right now, the results of the survey that you have conducted about juvenile detention centers and the population of those who are mentally ill in these institutions presents a sad picture of neglect. There is a national scourge with regard to treating our children who suffer from mental illness. Millions of our kids are going without the needed mental health care that they need. Studies show that 70 percent of our young people are in need of some mental health service and do not receive it.

When children with mental or emotional disorders cannot get the help they need, appalling and often entirely preventable outcomes result. They and their families suffer through unnecessary crises which can lead to school failure, dramatic out-of-home placements, and in some cases, arrest or suicide. Families unable to pay for services through private insurance or ineligible for services through the public health systems relinquish custody of their children to obtain state-funded services. Again, these are desperate moves. There are very few families who want to see their child punished without any prospect of a light at the end of the tunnel.

No family should feel that it has to relinquish custody of a child to obtain needed mental health services. Yet scores of parents across the Nation have surrendered their influence on key aspects of the children's lives to get access to public mental health services for their kids. This is a difficult problem to address, to be sure, and there are a couple of bills that would help. One, Madam Chairman, is yours, the Keeping Families Together Act, and I would like to be included as a co-sponsor. I think it has been done, but if not, I certainly want to be there.

Chairman COLLINS. We are pleased to have you.

Senator LAUTENBERG. I want to help you work with this problem, see if we can find a solution jointly. That one would lay a strong foundation for needed reforms by promoting access to these services and reducing fragmentation in service delivery.

Another is a bill that has overwhelming support in Congress, and that is the Senator Paul Wellstone Mental Health Equitable Treatment Act. This bill would build on a 1996 law prohibiting health plans that offer mental health coverage from setting lower annual and lifetime spending limits for mental illness treatment. In an April 2002 speech to mental health professionals in New Mexico President Bush said, the health insurance system must treat mental illness like any other ailment stating "that Americans deserve a health care system that treats their illnesses, their mental illnesses with the same urgency as a physical illness." I agree with the President's sentiment and I hope the administration, in the short time remaining in this session, becomes more involved in the issue. The President's support would go a long way in getting these bills signed into law before we adjourn in the fall.

I thank you, Madam Chairman, for doing this.

Chairman COLLINS. Thank you. Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thank you, Madam Chairman. I just came to see Henry Waxman. Henry, you are holding up well. I have known him for about 22 years. He looks today just like he did—either he

is aging gracefully or he just got old quick. I am not sure which. It is great to see you, and appreciate your work on so many issues.

Senator Collins and I are especially aware of the good work he is doing over in the House with Congressman McHugh on postal reform. We are mindful of that work and grateful for the opportunity to partner with you on that front.

I want to add a comment or two with respect to the issue that is before us today. I am not going to speak to serious mental disorders but I do want to talk about some of the briefing materials that I read on the hearing today, talk about a lot of students who are in special ed and how they end up in prisons. I do not know if you remember a fellow named Barry McCaffrey. Barry McCaffrey was the Nation's drug czar, retired general. He came to our State several years ago when I was governor, and he came to our State in order to put a spotlight on a program that we had put in place in all of our prisons called a Key and Crest program. Whenever people are within a year of leaving prison we would put them through an extensive program, last about half a year. We would follow up with them outside of prison. And we cut the rate of recidivism for people who completed the program from about 70 percent for most of our population down to about 40 percent, which is real progress. It is not zero, but it is a much-improved reduction in the number of people who come back to prison after they have been released.

I remember a conversation that he and I had with a lot of inmates in a room just a little bit smaller than this one. We had really about an extra half an hour to kill on our tour of Gandry Hill Prison in Wilmington, Delaware. We had about 70 inmates in the room with us. I said to the inmates—Delaware is a small State and you literally know almost everybody, and I knew a bunch of them. I said, how did you guys end up here? And a lot of them were young, late teens, early 20's. I said, how did you guys end up here? Just tell us your story.

About three or four took the advantage to do that and they told a story that was frighteningly similar. I was born when my mom was young. I never knew my dad. I started school and other kids knew how to read, they knew their letters, they knew numbers. They could already do that when they got to kindergarten. I could not, and I started behind. They knew words that I did not. I started behind and just got further behind. And I finally learned when a teacher called on me, in an effort to not be embarrassed by how little I knew, just to be disruptive, and to make them wish they had not called on me. Eventually they put me out in the hall or maybe sent me down to the principal's office. When I got older I found that if I was disruptive enough, rather than be embarrassed every day with just how little I knew, they would suspend me and maybe eventually expel me.

And I got out on the streets and did not have any skills or any knowledge, could not read or write, and the way that I could enhance my self-esteem was to turn to drugs or alcohol. And since I didn't have any skills to make a living, I turned to crime in order to get the money to buy the drugs or alcohol and make me feel better about myself. It was interesting, one after the other really told stories very much like that.

The point I want to make is this, and I know I have used too much time, there are amazing things that we can do with very young people to make sure that when they walk into kindergarten at the age of five and first grade at the age of six, they are ready to roll. They are ready to be successful.

In my State, we have just completed not long ago a longitudinal study where we took early age, we work with their parents to make sure that they had the skills that they needed to help prepare their kids for success, pre-K age three, age four, full day kindergarten for those kids, and then to use afterschool programs to work with those kids once they got in the first grade. We found at the end of the study period that we were studying these hundreds of kids, that we reduced by more than half the referrals to special ed. We found that those kids reached the third grade, that they were performing on par just about as well as other kids from normal, intact two-parent families where they had every opportunity.

The last thing I would say is this, we had a debate—not really a debate, but a discussion on the Senate floor a couple of months ago when welfare reform came up, and the issue we were debating was the Snowe amendment on the adequacy of funding for child care, quality child care for those whose parents are going off of welfare and going to work. Having a colloquy with Senator Chris Dodd, and I made the point, if you have got kids who grow up in a family where somebody reads to them literally from the start, just works with them on their vocabulary and exposes them to all kinds of experiences, good experiences, and works on their intellect, those kids will walk into the first grade with a 25,000-word advantage in their vocabulary over kids who have not had that opportunity.

And Chris Dodd said, no, you are wrong. It is 100,000 words. It is 100,000 words, the deficit that kids bring from a disadvantaged background where no one has been involved, no one has been preparing them. And we should not be surprised that when those kids get to school they fall behind, and they get in trouble. And when they get in trouble, they do not finish school. And when they do not finish school, they end up out on our streets and they commit crimes. A lot of them were in that prison that day, and some of them are probably still there. But we can do something about that.

Last P.S., if I may, Madam Chairman. It is a great story about an accelerated reading program in our State that has been introduced in a couple of elementary schools, actually in kindergarten. They have been able to work with kids in kindergarten so that by the time they finish kindergarten they are reading at a first and second-grade level. These are kids from from 30, 40, 50 percent free and reduced price lunch schools, and these are schools where they have taken the kids from almost nobody reading at a first or second-grade level to as many as 80 percent of the kids reading at a first or second-grade level. Kids you would never expect that to happen.

So I want to mention those things that happen in the real world every day. This is the real world too, but I wanted to share them. Thank you very much.

Congressman Waxman, Hon. Henry Waxman, great to see you.

Chairman COLLINS. Thank you.

It is now my pleasure to welcome our leadoff witness, Representative Henry Waxman. He represents California's 30th Congressional District. I understand that you first came to Congress in 1974. That was the same year that I first came to Congress, but I was a lowly intern for then-Congressman Bill Cohen, whereas you came as a powerful congressman, so there was quite a difference.

Since 1997, Representative Waxman has served as the ranking member of our companion committee in the House, the Government Reform Committee. He has established a special investigations division staff that has prepared many investigative reports, including the one that we are releasing today. As I mentioned in my opening statement, Representative Waxman has been a longtime leader on health care issues in the House of Representatives and I am very pleased that he is here today.

After your statement, Congressman, I would invite you to come up and join us up here, because I know you will want to participate further in the hearing. So please proceed with your statement and again, thank you.

TESTIMONY OF HON. HENRY WAXMAN,[1] A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Chairman Collins, for your leadership on this important issue, for holding this hearing, and for the extraordinary kindness you are showing me by inviting me to join you at the hearing. I think it is unusual to have a member of the House sit with the Senators, but on this issue we are not House members or Senate members, we are not Democrats or Republicans. We are people who care about an issue that we hope we can do something about. Senator Lautenberg and Senator Carper, thank you for your kind words. Senator Lautenberg about my work, Senator Carper, about the way I look. I will take whatever good comments I can get. But you two in your statements have expressed an extraordinary understanding of the loss to all of us in this country if we do not do all we can to help children realize their full potential.

What we are discussing today is a small issue. There are huge issues of how to make sure that everyone has the opportunity to succeed to the full extent possible. But in this particular situation there is an issue that I think we need to pay attention. Too often there is little connection between issues Congress addresses and the real problems facing our Nation. When foreign sales corporations seek change in the tax laws, as they are currently doing, hundreds of lobbyists come out of the woodwork and campaign contributions flow like water, and the attention of legislators become riveted on arcane provisions that have little relevance for most Americans.

But when there is a crisis in access to children's mental health services, that same sense of urgency is lacking. The problem is real and affects millions of families, yet without corporate lobbyists in the hallways or the prospect of sizable campaign contributions, the needs of children with mental illness have received little attention.

[1] The prepared statement of Mr. Waxman, with attachments, appears in the Appendix on page 31.

That is why your long term commitment to children's mental health care is so rare and so extraordinary. The fact that all three of you are taking your time to be here shows your commitment to trying to understand the problem and trying to think through what we can do about it.

The report we are releasing today is so important. I hope we can finally jolt Congress and the administration into action. Two years ago, at the request of Senator Jeff Bingaman and Representative Tom Udall, my staff investigated the fate of youth with mental illness in New Mexico who could not obtain care in their communities. What we found was deeply disturbing. One in seven youth in juvenile detention in New Mexico were there solely to wait for mental health services. Over 700 young people jailed simply because treatment was not available.

It was apparent to you, Chairman Collins, and to me that these inexcusable conditions were likely to extend beyond New Mexico, so at our joint request we asked the staff to expand its investigation. We surveyed every juvenile detention facility in the United States. We heard back from more that 500 administrators in 49 States, a response rate of over 75 percent. The resulting report is the first ever national study of unnecessary incarceration of children suffering from mental illness and here are some of the key findings.

Two-thirds of juvenile detention facilities in the United States lock up mentally ill youth because there is no place else for them to go.

Every day, about 2,000 young people are incarcerated simply because community mental health services are unavailable. This represents about 7 percent of all youth in juvenile detention.

In 33 States, juvenile detention centers hold young people with mental illness who have no charges against them of any kind.

Over 160 detention centers report that youth held unnecessarily have attempted suicide.

And children as young as 7 years of age are incarcerated because they do not have access to care.

Many of the detention centers we surveyed responded with written pleas. A detention center in Louisiana wrote, "We appear to be warehousing young people with mental illnesses due to lack of mental health services." A Washington State administrator said, "We have had a number of juveniles who should no more be in our institution than I should be able to fly."

A Tennessee administrator implored, "The last place some of these kids need to be is in detention. . . . Those with depression are locked up alone to contemplate suicide. I guess you get the picture."

And we get the picture, too, and it is deplorable.

The findings of this report indict how our society treats children suffering from mental illness in the United States of America in the 21st Century.

The report recalls the 19th Century. It recalls Charles Dickens and what he wrote about how people were treated in London at that period of time; and in this country, when reformer Dorothea Dix traveled from jail to jail gathering stories of individuals suffering from mental illness who were abandoned and ignored. Her work led to the creation of the Nation's first asylums.

Since the mid-1800's, psychiatry and associated professions have learned to diagnose and treat complicated mental illnesses. Hospitalization is now recognized as a treatment of last resort. It is well understood that many children with mental illness can recover and lead productive lives.

Yet even as scientific knowledge has advanced, our social policy has faltered. We have seen the emptying of psychiatric institutions without the establishment of community services. We have seen the starvation of public budgets that support the basic needs of millions of Americans with mental illness.

And today, the backbone of financing for children's mental health services, the Medicaid program, is in grave danger. Proposals to turn a guarantee of care into block grants for States could seriously compromise what little is left of the safety net.

The findings of this report call on us to reverse course.

Congress must ensure that adequate mental health services are available to all who need them. We must reform a confusing and bewildering mental health care system so that it works for the benefit of children and their families.

And we must insist upon accountability so that someone is held responsible each and every time a child is jailed to wait for mental health services.

We must work together—not as Democrats or as Republicans, but as Americans who care about children and their families—to end this warehousing of young people who are in need of treatment.

In closing, let me again thank you, Chairman Collins, for your leadership. I look forward to hearing the distinguished witnesses who will testify about these serious problems later this morning.

I hope we can learn more about this problem, draw some attention to it, and then think together how not to just ignore this problem but be constructive on a serious matter.

Thank you very much.

Chairman COLLINS. Thank you for your excellent testimony. I would invite you to come join us. To avoid giving my Republican colleagues a heart attack, I would suggest you sit on the Democratic side. [Laughter.]

But we would welcome you to come join us for the second witness panel.

I do want to salute you again for your excellent survey. It really was not only comprehensive—and I was pleased to join in supporting it—but it gave us for the first time a picture of just how widespread and serious this problem is. As you stated in your testimony, the fact that we have 2,000 children on any given night incarcerated who have done nothing wrong but are just simply ill ought to be a call to action for all of us. So thank you for your good work, and please do come join us.

Mr. WAXMAN. Thank you very much.

Chairman COLLINS. The Committee will now hear from representatives of the juvenile justice and mental health systems as well as from advocates for young people with mental disorders and their families.

First, I am pleased to welcome Carol Carothers, who is the Executive Director of the National Alliance for the Mentally Ill in the

State of Maine. She is also, I am very proud to say, the recipient of this year's highly prestigious Robert Wood Johnson Community Health Leadership Program Award for her efforts to prevent inappropriate incarceration and her advocacy for improving treatment for people with mental illness who have become involved with police and correctional institutions in Maine.

I will tell you, for the benefit of those of you who do not live in Maine, that Carol is known throughout the State for her tremendous advocacy on behalf of people who are suffering from mental illness. She is a hero with local law enforcement and sheriffs who too often find that people with mental illness are in their jails and prisons. And we are very pleased to have her here today.

The Committee is also very proud to welcome back Tammy Seltzer, the senior staff attorney for the Judge David L. Bazelon Center for Mental Health Law, which is a leading national legal advocacy organization for adults and children with mental disabilities. We worked with the center in our previous hearings last year, and we are very pleased to welcome Ms. Seltzer back.

Next I would like to introduce Leonard Dixon, who is the Executive Director of the Wayne County Juvenile Detention Facility in Detroit, Michigan. Mr. Dixon is also the President of the National Juvenile Detention Association and will be testifying on behalf of that association, as well as the American Correctional Association, and we are very pleased to have you here as well.

The Committee is also pleased to welcome the Hon. Ernestine S. Gray. Judge Gray has served in the Orleans—that may be a Maine pronunciation—Parish Juvenile Court in Louisiana as a judge for more than 19 years, and she has received national recognition for her work on behalf of children and their families. Welcome to you.

And last, but certainly not least, we will hear from Dr. Ken Martinez, the Director of Children's Behavioral Health for the Department of Children, Youth and Families in New Mexico. Dr. Martinez will tell us about some of the very innovative programs that have been initiated to address this problem in New Mexico, and we are very pleased that you could be with us as well so that we can see what can be done in a very practical way.

As you can see, we have assembled a very distinguished panel of witnesses. I am very pleased you could all be with us, and we are going to start with Ms. Carothers. Thank you.

TESTIMONY OF CAROL CAROTHERS,[1] EXECUTIVE DIRECTOR, NATIONAL ALLIANCE FOR THE MENTALLY ILL OF MAINE

Ms. CAROTHERS. Thank you, Chairman Collins and Members of the Governmental Affairs Committee. I am Carol Carothers, the Executive Director of NAMI Maine, which is the Maine State chapter of NAMI—the National Alliance for the Mentally Ill. Thank you for the opportunity to testify.

I can tell you that the findings contained in today's report are accurate. Youth with mental illnesses are held in juvenile detention because they cannot access treatment. We would not dream of placing a child with cancer, for example, in juvenile detention to await

[1] The prepared statement of Ms. Carothers appears in the Appendix on page 57.

treatment. It is outrageous that we do this to children with mental illness, and there are four points I would like to make today.

One, children and families are suffering unthinkable consequences from this crisis. My first involvement with this issue was the death by hanging of an 18-year-old whose mental illness and substance use disorder had been untreated for years. He died in Maine's most restrictive prison—the super-max—because he was suicidal and no hospital bed could be found.

More recently, Maine settled a lawsuit on behalf of a child committed to the youth center at age 13. He was suffering from depression and suicidal ideation, held in isolation for 152 of his first 240 days. Each of five future admissions also resulted in long periods of isolation, behavior deterioration, depression, aggression, and eventually self-mutilation.

Just last week, I spoke to two moms. Both tried unsuccessfully for years to secure school-based services for their mentally ill sons. The schools sent them home or suspended them for not following school rules. The moms nearly lost their jobs. The other children begged to have their brothers kicked out. Eventually, the courts, with few resources, incarcerated them. Once incarcerated, the boys lived with more accomplished juveniles. One mom said, "If I could ask anything, I would ask, 'What money did you save by denying my son mental health treatment and services?'" The second mom said, "My son learned to cut himself in there."

Two, juvenile detention centers are the worst possible environment for children with mental illnesses. Many of the techniques used in correctional settings, like prolonged isolation and restraint, actually lead to increased, not decreased, acting out and self-harm, particularly among youth with mental illnesses. When children are detained in juvenile centers in Maine, they are housed in a single unit where 10-year-olds can be housed with 20-year-olds. Providing for their individual needs is extremely difficult. Staff can spend most of their time protecting the vulnerable kids from the predatory kids, especially when a unit designed for 30 houses 43. Correctional settings are slow to respond to kids with undiagnosed disabilities, leading to deterioration in mental status, increased violations of rules, and increased discipline. The unfortunate reality is the more experiences youth with mental illness have in juvenile detention, the more likely they will descend deeper and deeper into the criminal justice system.

Three, Maine, like most States, lacks adequate home and community-based services. Most States lack adequate home and community-based mental health services. Maine spends 60 percent of its scarce dollars on institutional services, despite the fact that home and community-based services cost less and produce better outcomes. It costs between $50,000 to $80,000 a year for detention and about $30,000 to provide intensive in-home services for a family for 1 year.

Too many youth housed in juvenile detention centers graduate to the adult correctional system. The United States has the largest number of incarcerated citizens in the world, and we open four new correctional institutions every month. We must not become a Nation that spends more to incarcerate children than to educate or provide treatment for them. Money cut from mental health and

substance abuse services is shifted to corrections budgets, a waste of taxpayer money and an inhumane and counterproductive way to treat children and adults with mental illnesses.

Four, what can be done to help end this crisis? Enact the Keeping Families Together Act, which would help end the tragedy of custody relinquishment.

Enact legislation to help improve access to essential evidence-based, community-based services for youth with mental illness and their families.

Enact the Mentally Ill Offender Treatment and Crime Reduction Act which would authorize funding to help States reduce the high percentage of youth and adults with mental illnesses locked up in jails and prisons.

Enact the Senator Paul Wellstone Mental Health Equitable Treatment Act, which will assure access to treatment.

And enact the Family Opportunity Act to allow families with children with serious disabilities to buy into the Medicaid program.

In closing, I would like to thank Senator Collins and Representative Waxman for their leadership in requesting this report. I would also like to share with the Committee that in preparing my remarks for this hearing, I spoke with families, inmates, and advocates, asking: What is the most important thing that I should say? The answer they all agreed upon was: Make sure they understand the urgency of this issue. Thank you.

Chairman COLLINS. Thank you. Ms. Seltzer.

TESTIMONY OF TAMMY SELTZER,[1] STAFF ATTORNEY, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

Ms. SELTZER. Good morning, Chairman Collins, Senator Lautenberg, and Congressman Waxman. Thank you for the opportunity to speak.

On any given night, nearly 2,000 children and youth—some as young as 7 years old—languish in juvenile detention facilities around the country solely because they need mental health services.

Until now, public policy circles have largely ignored this issue, but thanks to Chairman Collins and Congressman Waxman, we now know how widespread this tragedy is.

I am not going to highlight any of the findings of the report, just to say that they are consistent with what we have been hearing from families and advocates around the country. Although the issue of victimization was not addressed in the report, I think it is important to note that these incarcerated youth are also more likely to be victims of violence in these detention centers because they are perceived as more vulnerable.

My testimony today will address the causes of this tragedy, describe the kinds of services and supports that children need to avoid ending up in juvenile detention centers, and outline steps that the Federal Government can take to make a difference for these children and their families.

According to the detention center administrators, these children they identified for the survey should not be in their facilities and

[1] The prepared statement of Ms. Seltzer appears in the Appendix on page 63.

would not be there if appropriate community mental health services were available.

Children with mental disorders are funneled into the juvenile justice system through a variety of ways. Number one is the lack of access. In most communities, the public mental health system is open from 9 to 5, when most children are in school. The police department, on the other hand, is open 24 hours a day. I think that fact right there explains why so many children are ending up in detention facilities.

But there is also a lack of accountability and a bias toward law enforcement solutions. The agencies responsible for supporting parents and treating their children pass the buck by telling parents that they should call the police for help. In one case, a mental health crisis line designed to aid parents in just these situations called the police rather than sending out a mental health crisis team.

There is also a lack of comprehensive private and public insurance for mental health problems, as was mentioned earlier, and a lack of coordination. The public agencies that serve children are so uncoordinated that children can end up with several diagnoses, and each agency ends up referring the child to another agency for services that do not even exist.

While model programs are far too rare, effective alternatives to incarceration do exist. One such program, Wraparound Milwaukee, works closely with parents to provide services tailored to the needs of each child so children can stay out of crisis and out of the juvenile justice system. The program is reducing costs and—more important—reducing the number of children who end up in juvenile detention centers.

Fortunately, we know the principles that make programs like Wraparound Milwaukee successful. Children and their families must have ready access to mental health services and supports. This access has to be based on real kid time and not bankers' hours. Services and supports must be designed to enable children to succeed and not just avoid detention, and child-serving agencies need to work together and be held accountable. And the Federal Government can play a key role in addressing this problem, both through Federal agency actions and through specific legislation.

According to today's report, the General Accounting Office recommended that the Department of Justice "track the inappropriate detention of mentally ill across the country." Given the seriousness of this situation, we urge lawmakers to require the Department of Justice to reconsider GAO's request and also encourage the Department to enforce the law.

But simply closing the door to juvenile justice is not a panacea. For example, the report notes that many children are languishing in these detention centers because there is a lack of specialized foster care placements. Obviously, children should be kept at home whenever possible, and necessary services should be brought to them there. But when that is not possible, therapeutic foster care has proven effective.

States can use Medicaid to help pay for the services that are provided with therapeutic foster care, but far too few States take advantage of this because they are confused about Medicaid law.

CMS, the Center for Medicare and Medicaid Services, could clear up these misunderstandings by issuing a memo to State Medicaid directors.

In 1997, the Individuals with Disabilities Education Act was reauthorized to explicitly require schools to respond proactively to problem behavior of students when it affects their learning or the learning of others. But too few schools have embraced these positive behavioral supports. Instead, they rely on zero tolerance policies, suspensions, and expulsions, and, increasingly calling the police—tactics that do nothing to improve student behavior and only increase the likelihood they are going to end up in the juvenile justice system. The Department of Justice must do more to enforce IDEA.

In terms of specific legislation, the Family Opportunity Act, as Ms. Carothers mentioned, is something that would enable more families to have access to Medicaid. And the Keeping Families Together Act, which Chairman Collins has introduced, along with others, is a very important specific piece of legislation that would help reduce the number of children with mental or emotional disorders by supporting States' efforts to develop coordinated systems of care.

When I last appeared before this Committee last year to talk about custody relinquishment, I discussed the GAO study that Chairman Collins mentioned. And as someone working in mental health for 8 years, what was shocking to me was not the number of children that families were giving up, because I think that 12,700 number is actually an underestimate. But what was the most shocking is where those children were ending up. Two-thirds were ending up in the juvenile justice system, not child welfare.

I want to commend Senator Collins and Congressman Waxman for commissioning this important report, and hopefully by providing this kind of information, we can address the problems so that parents do not have to face this tragedy. These children languishing in juvenile detention centers are being thrown away like yesterday's garbage, but they are tomorrow's adults. And as Congressman Waxman said, if we are denying them their potential, that would be the greatest tragedy of all. Thank you.

Chairman COLLINS. Thank you. Mr. Dixon.

TESTIMONY OF LEONARD DIXON,[1] PRESIDENT, NATIONAL JUVENILE DETENTION ASSOCIAITON, AND EXECUTIVE DIRECTOR, WAYNE COUNTY JUVENILE DETENTION FACILITY, DETROIT, MICHIGAN

Mr. DIXON. Good morning. Thank you for the opportunity to testify before you today, and I would like to ask that my full written testimony be entered into the record.

Chairman COLLINS. Without objection.

Mr. DIXON. I am Leonard Dixon, President of the National Juvenile Detention Association and the Executive Director of the Wayne County Juvenile Detention Facility in Detroit, Michigan. I wish to thank Chairman Collins, Senator Lieberman, and Representative Waxman for their leadership on this issue and for inviting me here today to discuss with you my views on the report submitted by the

[1] The prepared statement of Mr. Dixon appears in the Appendix on page 76.

Government Reform Committee on incarcerating mentally ill youth awaiting community placement in the United States.

The report serves to highlight the seriousness of one of the most difficult issues facing all juvenile detention centers across the Nation, and its impact on the daily operations of these facilities across the country cannot be underestimated.

In Wayne County last year, there were 4,152 youth between the ages of 10 and 17 that were identified in our facility, that came into our facility. Of that, 2,331 of those youth, 56 percent, needed and received mental health services. There are several factors within the field of juvenile justice that constitute a reasonable argument to ensure that the inappropriate placement of youth with mental health issues in detention ends. The most compelling argument is that detention for youth is generally short term and does not include nor guarantee the provisions of any type of formalized treatment to address identified disabilities, including mental illness. Youth with mental health issues require support and management services that often exceed the level of training provided in detention facilities.

A second reason for ensuring that youth with mental illnesses are not detained in juvenile detention facilities is that they are more difficult to manage, more explosive, more easily agitated, require more intensive supervision, and create more strain on direct care staff than other youth within the juvenile facility. Management of youth with mental health issues results in a higher number of injuries to both staff and youth, the destruction of property with building repairs. Most juvenile facilities do not have the luxury of separating youth with mental health issues from the general population. This creates an atmosphere of conflict and unrest for everyone, and the potential for crisis can be very high.

I would like to give you a couple of stories. The first involves an 11-year-old female youth. At the age of 8, she was hospitalized in a psychiatric facility for the first time because of aggressive behavior towards her mother. Before entering the juvenile justice system, she had two more inpatient psychiatric hospitalizations. She still began to develop anxiety about school and in the fifth grade refused to go to school. Because of her mental health history, she came into our facility. At that time, it was very apparent to the mental health team that her difficulties were related to her relationship with her mother and would be best addressed by family therapy.

The youth was returned to our facility in less than 5 weeks because her mother told the court that her daughter was refusing to follow directions. She remained in detention for an additional 3 months as she awaited placement for community services.

The second case is a clear example of the failing of our Nation's foster care system. It involves a 15-year-old male who entered the foster care system when he was 9 because of abuse and neglect. The youth had never returned home since that time. He has been in and out of our facility at least eight times. He has had stints in short-term psychiatric hospitals and has been in many residential facilities.

During his last stay at our facility at Christmas, he was very depressed and began to engage in self-mutilating behavior. As a re-

sult, he was placed on constant watch. He told the detention staff that he had swallowed a piece of glass and was sent to the emergency room. From there he was transferred to a psychiatric hospital for treatment of his depression. After 3 days, he pulled the fire alarm at the hospital and escaped.

He had planned all along to go back to his old neighborhood and look for his family. He managed to elude the authorities for several months. He found some relatives. Upon his return, he was disillusioned about his family and sadly reported that he felt unconnected to them.

The need for collaboration with mental health agencies in the community is often very difficult but extremely important in terms of taking care of these youth. The most critical reason for the gap in networking on behalf of youth is the lack of coordinated communication between mental health and juvenile justice systems. The correction community has long been sympathetic to the need of juvenile offenders with special needs. In 2001, the National Juvenile Detention Association adopted the following position statement—which I will not read for the lack of time.

Despite our efforts to ensure that those in need of mental health services do not end up in our custody, parents are often forced to choose the confinement of their children with mental health issues in a detention center as a two-pronged solution to the crisis.

In closing, I have nine areas that will be in the record, but one I would like to cite particularly: The issue of Medicaid funding. What happens in our country is that when a youth is brought into a public detention facility, the Medicaid funding is usually cut off, which means that the money is not following the kid, the kid is following the money. And with that, it has become—other funding sources identified for youth services must follow the youth and not become available only when the youth enters the system as designated levels of care. Special emphasis must be placed on mental health parity with medical services for our most vulnerable resource. And I would say what my father would say a long time ago: You cannot cripple a person and then criticize the way that they walk. When we place kids in institutions without having the proper services, the proper appropriate services for them, then we are asking the facilities to perform at a level that they are not capable of doing. And most detention centers in the country do not have mental health services, so you are placing kids with those problems in with kids who are purely delinquent kids, and we are asking for a good result. That will never happen.

So I would like to thank you again, and the bills that are currently before Congress are two bipartisan proposal that merit consideration and swift approval, which would help to fill the gap between treatment and detention: The Keeping Families Together Act, introduced by Senator Collins and others, and the Mentally Ill Offender Treatment and Crime Reduction Act.

Thank you very much.

Chairman COLLINS. Thank you, Mr. Dixon. Judge Gray.

TESTIMONY OF HON. ERNESTINE S. GRAY,[1] CHIEF JUDGE, ORLEANS PARISH JUVENILE COURT, NEW ORLEANS, LOUISIANA

Judge GRAY. Good morning, and thank you for the invitation to participate in this hearing. I am a juvenile court judge from New Orleans, Louisiana, having been on the bench for over 19 years, and my 19 years on the bench has given me a wealth of knowledge and experience dealing with the juvenile justice issues. I have served on many boards and commissions regarding juvenile justice issues. I have served as a member and past president of the National Council of Juvenile and Family Court Judges. I want to thank you for your efforts in this area and your attention to this important issue, and I would like to say that this is long overdue.

No one can doubt that there is a serious issue as it relates to the mental health of our children, and an equally serious issue with the way we provide treatment, when and if treatment is provided.

All of my experience over the past 19 years is consistent with the findings of the report being released today. All too often, children charged with delinquent behavior are identified early on as needing mental health services. However, because those services are not available, the children are sent back to their families with no supports until there is another violation. Many times it is only after several brushes with the law, each time a little bit more serious, before everyone is fed up and then the solution is to incarcerate the children for a reason, and the reason being so that they can get mental health services that they need.

Judges I can tell you, are frustrated on a daily basis by having to be put in a position of knowing that the only reason really we are incarcerating children is so that they can get mental health services. I am a judge who believes very much in due process and procedural rights, and I have been known on the bench to say daily, "This is not right. We should not incarcerate children just because they are ill." And many times I have found in cases that we seem to be just making up violations so that we can get them into the system and get them services. And you have already heard from Mr. Dixon that those services that they need are generally not provided because those facilities are not equipped to provide the mental health treatment that the children need.

Judges are faced with families many times a day who are saying, "We cannot do it any longer. We are unable. We do not know what else to do. And so I want you to take them. I am not taking them home. I refuse to take them home because I am afraid of them, I am afraid of what they might do to me, what they might do to themselves, or what they might do to someone else." And so they bring them to court many times, and they leave them on the doorsteps of the court, and the judges are then faced with what to do with these children.

These issues cut across both delinquency and dependency cases, and it is not a surprise that many children who are abused and neglected many times end up in the juvenile delinquency side. It is unfortunate that there is a high correlation between the children who are in our dependency caseload and those who are also in our

[1] The prepared statement of Judge Gray appears in the Appendix on page 87.

delinquency caseload. Children who have been abused and neglected many times end up incarcerated, again, because we are not able to provide the services that they need. They have bombed out of their foster home placements. The caretakers are saying, "We can no longer provide the services that they need in the home, and so you need to find another placement for them." And many times, the only placement we can find, especially on short notice, is a placement that is in a detention facility.

Status offenders, children who are runaways, who are truant, who are ungovernable and unruly, many with mental health issues, are detained or locked up "for their own good"—because that is the only way that judges think they can keep them safe.

I have looked at many of the bills that are pending and that have been introduced to address this issue. My concern is, for example, on S. 1704, it sets up a competitive grant process. I long for the day—I do not mean this to be disrespectful. I think that it is good. But I long for the day when children will be able to receive services that they need in their State, regardless of whether or not a State agency is able to write a competitive grant. We are concerned about the families relinquishing their children to get services. Are we also setting up a situation in which they will have to move to another State to get services? In this country, I do not believe that is appropriate. It is inconsistent with what we say about children being our greatest natural resource. Children deserve the services that they need no matter what State they are in purely because they are in this country and are part of our citizenry.

One of the problems that I see that I do not believe is addressed, I think that there is a lack of specialists—psychiatrists and psychologists with the special training to deal with young people. And one of the things I would hope that we might be able to do is sit down with some of the medical schools and universities and try to figure out if there is a way that we can develop a larger pool of people who are specially trained to deal with children—child psychiatrists and psychologists. And I believe that we can do that, perhaps looking at what was done in the area of legal aid when there was a lack of attorneys in the South. There were programs that were developed that would recruit and then help those persons pay back their school loans, any number of things so that we would be able to recruit the kinds of people that we need. So I would urge working with medical schools and universities to address that issue.

There are a couple of recommendations that I would like to make, and I think we all know what is needed, but I would just say them for the record so that we can be clear:

Twenty-four hour availability of services.

Standardized screening and assessment. It seems to me it makes no sense to have one screening for juvenile justice and one screening for mental health when we know the children are all the same. So let's get together and decide what is the best assessment tool that we all can use that will provide the information that we need in order to be able to effectively treat the young people who are appearing in our systems.

Better communication and coordination interagency and intersystem. This means developing the capacity and ability to share in-

formation across systems about the children that we are working with.

Community-based programs. It has already been talked about.

Integrated treatment across all systems, that is, child welfare, juvenile justice, mental health, special education, and substance abuse.

More research on the prevalence of mental health disorders among youth. And it has already been suggested and I would second that: We are urging the Department of Justice to track the inappropriate detention of youth with mental illnesses across this country.

No matter how hard we try, we may not be able to treat all children outside of detention. Nonetheless, children who are rightfully detained, these children need treatment for their mental illness, mental disorders, and you have already heard that in the juvenile detention centers that is not appropriate. And so we need to work on the treatment that we are providing for those children who are legitimately detained.

In order to effectively serve this population, the juvenile justice system and the mental health system must work together to develop programs and services for these children. These services need to be appropriate for the child's age, gender, and culture, individualized and family-focused.

I would also urge—I would be remiss if I did not urge you to look closely at what happens to youth of color in the juvenile justice system. They are overrepresented in the juvenile justice system and many times underserved by the mental health system. So as you are looking at this issue, I would encourage you to pay some attention to that as well.

I thank you again for the opportunity to be here this morning and look forward to having a discussion with you during the question-and-answer period. I would tell you that the juvenile judges from around the Nation are profoundly interested in this work, and we are willing to work with you to find solutions that improve the lives of these children and families. Our detention facilities should not be used as substitute mental hospitals. Thank you.

Chairman COLLINS. Thank you, Judge. Dr. Martinez.

TESTIMONY OF KENNETH J. MARTINEZ, PSY.D.,[1] DIRECTOR, CHILDREN'S BEHAVIORAL HEALTH, DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES, STATE OF NEW MEXICO

Dr. MARTINEZ. Thank you, Senator Collins, for the opportunity to be here today, and thank you to Senators Durbin and Lautenberg, and Congressman Waxman also.

I would like to share with you some approaches that we have in dealing with juvenile justice clients in our system in New Mexico, but first I am going to make some key points about the national scene.

First, the prevalence of mental health disorders among youth in the juvenile justice system is two to three times higher than among youth in the general population. Anywhere from 70 to 100 percent

[1] The prepared statement of Dr. Martinzes appears in the Appendix on page 89.

of youth in the juvenile justice system have a diagnosable mental health disorder.

Second point: The mental health and substance abuse needs of the juvenile justice population have been neglected. There is a growing concern over the criminalization of mental illness among our juvenile population. The juvenile justice system as well as the child welfare system are becoming the systems of last resort.

And the third point: There are new and effective tools and services that are demonstrating real promise for youth in the juvenile justice system. We now have screening and assessment tools that have been specifically designed for youth in the juvenile justice system that have proven to reduce long-term rates of re-arrest, improve family functioning and school performance, and decrease substance abuse and psychiatric symptoms.

Now I would like to take the opportunity to comment on Representative Waxman and Senator Collins' report.

First, I want to thank Representative Waxman, Representative Udall, and Senator Bingaman for choosing New Mexico to highlight the problems that are occurring around the country. We were the first to be highlighted, and that has really helped us move forward in taking the next steps to remedy the situation. So thank you, Congressman Waxman.

As was implied in the report, juvenile detention centers—and, I might add, State correctional facilities—have become the de facto psychiatric hospitals and residential treatment centers for mentally ill youth. These youth require appropriate clinical services, professional clinical staffing, and evidence-based programs.

Second, detention, especially unnecessary detention, for children and youth with mental health needs who are not properly screened, evaluated, and treated causes harm to these children and youth. Undiagnosed and untreated mental health disorders are exacerbated by the conditions of confinement.

Third, youth who are detained for the sole reason of awaiting treatment in the community are predictably going to have a deterioration of functioning and an increase in symptoms, such as suicidal ideation and attempts, and those are the only likely outcomes that will occur while they await transfer. Consequently, their course of treatment may be lengthened when they eventually receive it.

And, fourth, community-based services are needed and yet are not plentiful to meet the need. Culturally competent treatment that involves the family is a necessary prerequisite to success.

The following describes some of the work that we are working on in New Mexico, and we admit that we still have a long way to go.

From 1991 to 1999, the Bernalillo County Juvenile Detention Center, which is where Albuquerque is located, housed 130 to 140 clients ages 8 to 18, with an average length of stay of 33 days each. Through collaboration and ongoing support of the Annie E. Casey Foundation, and utilizing best practices from other States, the Bernalillo County Juvenile Detention Center managed to accomplish many things. It now has an average daily census of 65, down from 140; with an average length of stay of 9 days, down from 33 days, including for the most serious youthful offenders; a recidivism rate of 13 percent, down from 46 percent; and the cost for se-

cure detention a day was $96, and now the cost of the community custody program is $19. Still, we have 73 percent of currently detained clients having at least one mental health diagnosis in those clients that are in detention.

Now, how was all this accomplished? The Children, Youth and Families Department, the department that I work for—which is responsible for children's behavioral health, juvenile justice, and child welfare—along with the Human Services Department—which is the Medicaid State agency—the Department of Health—which, among other things—the Bernalillo County, the University of New Mexico Health Sciences Center, the three Medicaid managed care organizations, and children's court judges all collaborated, culminating in the Children, Youth and Families Department licensing the Bernalillo County Juvenile Detention Center as a "Children's Community Mental Health Center," which allowed for Medicaid billing of all medical and behavioral health services provided to non-adjudicated youth. The University of New Mexico also contracted child psychiatric staff and other providers to staff the center. Since it opened in 2002, the Children's Community Mental Health Center, on the campus of the Bernalillo County Juvenile Detention Center, has seen 1,200 children.

The detention center has a relationship with a local adolescent shelter care provider to be a reception/assessment center in lieu of detention for minor offenses that are frequently mental health or substance abuse related. Police take juveniles that are picked up to the reception/assessment center for mental health/substance abuse screenings and evaluations and treatment.

We have four social workers in the Albuquerque Police substation and the sheriff substations to work with youth and their families at the time that they are picked up to avoid unnecessary detention.

The Bernalillo County Juvenile Detention Center operates a Youth Reporting Center on its campus that is open 7 days a week from 8 a.m. to 8 p.m., offering academics, recreation, workshops, and other similar activities.

The detention center has a community custody program to supervise youth at job sites and at schools.

In addition to the county initiative, the Children, Youth and Families Department's Juvenile Justice Services has worked closely with the New Mexico Juvenile Parole Board to parole technical violators and low-risk clients with low to high needs, who can then be referred to community programs.

Our Department has reduced its statewide correctional facility census from 625 to 270, as of this week, a decrease of 55 percent. Consequently, we closed our 96-bed maximum security correctional facility last week, July 1 of this year. These reforms are a result of many factors, including juvenile detention reform, juvenile drug courts, re-education of juvenile probation and parole officers, law enforcement, juvenile court judges and attorneys.

Additionally, our department has redeployed 41 positions that used to be employed in the maximum security facility to "front-end" services in communities, including to provide client supervision; regional coordinators to identify and develop programs in rural and urban communities; and to become functional family therapists and

multi-systemic family therapists in the community. The Annie E. Casey Foundation is assisting New Mexico to replicate this model in seven other communities.

Conclusions: The solutions are not simple. They involve cross-system solutions. There is an obvious blurring of roles and responsibilities of child-serving systems, and that is a good thing because no longer is a child or youth exclusively a child welfare client or exclusively a juvenile justice client or a mental health client. They are the same child or youth in more than one system. They are all our children and youth regardless of the system door they enter.

We in the New Mexico juvenile justice, mental health, and child welfare systems applaud you, Senator Collins, and your colleagues for introducing Keeping Families Together Act. It not only will provide funding for interagency systems of care for children and adolescents, but it acknowledges the cross-system complexity in defining the problem and in defining the solution. For too long, our child-serving systems have not worked together and, therefore, have missed opportunities to collaborate, share resources such as joint planning, program development, and human and financial resources. We have failed to function either as one child-serving system or as a coordinated and collaborating set of jointly responsible and responsive child-serving systems. Keeping Families Together Act would be one major step forward in promoting the cross-system collaboration, and it certainly complements the New Freedom Commission Report on Mental Health that also advocates for more and effective cross-system collaboration.

There is much more that needs to happen, and we as policymakers need to recognize that meeting the behavioral health needs of our juvenile justice population in detention is critical.

Many of the youth detained are in for relatively minor offenses. Diversion programs need to be developed, and we need to advocate for and fund more community-based options that will provide mental health and substance abuse treatment to these youth in their own communities and give judges, such as Judge Gray, options other than incarceration. The research suggests that this is the most effective approach.

While we are doing a better job at screening and assessment, we need to advocate for and fund universal screening for all youth entering detention and provide evaluations and treatment when necessary in appropriate community-based settings.

And, finally, community re-entry programs for youth transitioning out of detention and correctional placements need to be strengthened to maximize success and reduce recidivism in both the detention system and restrictive mental health settings.

Thank you for your concern over this issue. Our collective goal is to improve conditions for our youth and provide the needed services and supports to them and their families.

Thank you, Senator.

Chairman COLLINS. Thank you. That testimony was very encouraging, and I look forward to questioning you, as I know the panel does.

I am going to begin with Ms. Carothers with a question. I know that you have done a great deal of work with Maine's inmate population with a focus on adult inmates who are living with mental ill-

ness. Could you give us some idea of how many of those adult inmates were also involved in the juvenile justice system?

Ms. CAROTHERS. Most of the inmates that I have worked with were involved in the juvenile system. I interviewed 40 inmates in Thomaston Prison a couple years ago, and they all told the same story, which is poverty, foster care, a youth center, Wyndham, which is the first step, and then the higher prison, Thomaston. I think the recidivism is enormous, and I think it starts in juvenile, absolutely.

Chairman COLLINS. I am struck by Dr. Martinez's statistic that most youth in the juvenile justice system have diagnosable mental disorders. In fact, it may be as high as 70 to 100 percent, which is huge. Does that suggest to you, Ms. Carothers, that if we were to invest in mental health services for youth, we would greatly reduce the adult population in prisons?

Ms. CAROTHERS. Prevention is everything, and so if you can catch kids early, you would absolutely make a difference in the whole system, the numbers in the adult system and the numbers in the juvenile system, start earlier.

Chairman COLLINS. Judge Gray, could you give us an idea based on your 19 years on the bench of how many of the youth who come before you either have problems with mental illness or substance abuse? What percentage would you guess?

Judge GRAY. I would guess clearly 70 to 85 percent of the kids who come before the court have a mental health issue and/or a substance abuse issue, because we do have co-occurring disorders, and so you have some children with both. But 70 to 85 percent of them have one or the other.

Chairman COLLINS. Dr. Martinez, this suggests to me that an investment in community-based mental health care for juveniles can save not only a great deal of human suffering for these individuals and their families and communities, but also save a great deal of money as well in the long run. Was it difficult to convince the legislature in your State to make the up-front investment in mental health services that you are already starting to recoup? How did you convince policymakers in your State to make that up-front investment when they have to wait a bit for the savings to be realized? Even though it sounds like you have been able to realize savings as well as considerable public policy improvements rather quickly.

Dr. MARTINEZ. Well, the investment is economic, certainly, but most importantly, it is an investment in our youth so that they do not become inmates of correctional facilities as adults.

We are still having our struggles in convincing everyone, yet our efforts really are a bipartisan effort within our State legislature, led by our governor, to really make improvements in prevention and early intervention. We have spent many dollars in high-end services, as we call them, in correctional facilities. Redeploying those 41 full-time employees and putting them in communities is going to be an argument that hopefully will convince the rest of our legislators that this is a worthwhile effort.

It is a long-term investment. It is very hard to convince people without data that, for the short term, prevention is worth the effort. And yet everything indicates to us that it is the only invest-

ment that is going to help us save our children and save money as well.

Chairman COLLINS. Mr. Dixon, I was impressed in your testimony when you said that 56 percent of the people coming to your facility actually received mental health services. It seems to me that you are more advanced than many facilities if you are doing that kind of screening up front to identify people who need mental health services.

Is your experience typical? Or do you think that it is unusual to have a system that does that kind of screening and provides these kinds of services?

Mr. DIXON. Madam Chairman, it is almost laughable that we do not have this going on in most facilities in the country. We are very unique, in Michigan. And, I will say this: One of the reasons why that occurred and the reason why I am in Michigan is because we were being investigated by the Department of Justice. And it is a shame that what is starting to happen in this country is that no one wants to fix anything until the Department of Justice comes in and says that you have all of these problems. And we keep saying fix the problem up front, then you do not have to pay for it, because you spend a lot of money when you get into lawsuits, into litigation, and all those kinds of things.

And so we have been stressing with folks around the country to fix your problems prior to someone coming in to tell you that they need to be fixed.

Chairman COLLINS. Ms. Seltzer, I was very pleased that you gave us some specific actions that we can take, and we would like to work with you in encouraging CMS to issue the memo on therapeutic foster care that you mentioned.

My time has expired so I need to wrap up quickly. But could you tell us a little more about the Wraparound Milwaukee program that you indicated as being a promising approach?

Ms. SELTZER. Certainly. Wraparound Milwaukee has been around for a number of years, and it targets children who are in the juvenile justice system. At least initially that is what it did, and now it has expanded to focus on children who are at risk of entering the juvenile detention system.

It works very intensely with schools and the mental health system and child welfare system to provide services to children in their homes where they live so that they are able to not only avoid juvenile detention but to be successful in school and in their communities and to be able to live with their families.

Chairman COLLINS. Thank you. Congressman Waxman.

Mr. WAXMAN. Thank you very much.

When we were trying to find out about this problem of unnecessary detention of children because they could not get access to mental health services, we wrote to the juvenile detention facilities, and we got a real strong response, not just giving us the information but anger and frustration by many of the administrators of these facilities that they were being used as warehouses.

Mr. Dixon, is it true that they cannot turn anybody away? And is it your sense that other agencies and insurers are just saying no more and that is why they are ending up in your facilities?

Mr. DIXON. Yes, that is correct, Congressman. One of the things that we keep saying is that detention has become not only the dumping ground, but it is the emergency room of whatever goes on in the systems, because no one can handle—no one wants to handle the kid. I was struck by an article last week in the *Miami Herald* where three girls who were in a mental health facility tried to escape, and they placed them in a detention facility for 21 days because they were trying to escape from a mental health facility. Well, to me, that is backwards.

And so, yes, it has become almost unbearable because we are talking about money here, and we are having staff who are injured because they are not trained to deal with kids who have these kinds of problems. And if you are going to do it, then you are going to have to put in training and all those things in the institutions, and that is not happening.

And so we have been very fortunate in Michigan, but it is a major issue for every detention facility in this country.

Mr. WAXMAN. Thank you very much.

Ms. Carothers, I wanted to ask you: Some people might say the best way to solve this issue or to deal with it is to get services in the detention centers. Is that going to be a good way to make sure that children have access to what they need?

Ms. CAROTHERS. You need services in the detention centers for those kids who you cannot keep out. But what you really need is diversion, and diversion is just a word unless you have something to divert people to, which means services. So you actually have to have diversion, and you cannot have diversion unless you have a lot of mental health services in the community. And those need to be evidence-based blueprint services where folks have the understanding to treat people with dual disorders and who have criminal justice involvement. Oftentimes our mental health centers do not have that expertise.

Mr. WAXMAN. In other words, a lot of kids just should not be in the detention center at all. They should be getting care elsewhere, either in the community mental health centers or hospitalization or child welfare agencies of one sort or another. Is that the——

Ms. CAROTHERS. I do not think they would be in the criminal justice system if the safety net service system was there.

Mr. WAXMAN. And, of course, they are not, for many of them, even involved in any kind of criminal activity. On that point, somebody said "criminalization" of mental health is what is going on.

Mr. Martinez, I am pleased to hear what you had to say about the fact that when Senator Bingaman and Congressman Udall asked us to do this evaluation, we started in New Mexico, and it seems to have led to a number of reforms in your State to try to actually come up with some ways to deal with this problem. You went through some of the points, but I was interested, particularly because I have a background in this area, how you use the Medicaid funding to accelerate the transition from juvenile detention to mental health, and community mental health services. Were you able to figure out some way to draw more Federal dollars so that these services would be available under Medicaid? So many of these children are going to be eligible for Medicaid, if not all of them, because of the institutionalization.

Dr. MARTINEZ. Well, what we have done is for non-adjudicated youth, we have accessed Medicaid services because that is certainly allowable. So for those kids that have been diverted from detention and can be served in the Children's Community Mental Health Center or who are released from detention who are Medicaid-eligible by income, we certainly can serve them in the Children's Community Mental Health Center. So we are not drawing down any more or different kind of funding for Medicaid, but certainly we utilize it quickly. And with presumptive eligibility, which is allowed under Title 21, the State Children's Health Insurance Program, we are able to make children presumptively eligible upon release from detention or at the Children's Community Mental Health Center itself.

Mr. WAXMAN. So you are using the system the way it was intended, to make sure that children get preventive services through Medicaid, but preventive health services, in this case mental health services, to deal with the problem before they have to be put into some kind of detention center incarceration.

Dr. MARTINEZ. That is correct, Congressman.

Mr. WAXMAN. Any other strategies you have employed for preventive purposes?

Dr. MARTINEZ. Well, again, we have our social workers in the police substations and the sheriff substations in order to divert kids when they are picked up in the middle of the night, or whenever they are picked up. This is to avoid incarceration by working with the family at the very moment that the crisis is happening because crises do not wait for 8 to 5, and families are in need 24/7, as we have heard. So we do not want our detention centers to be the emergency rooms anymore. So that is one strategy.

We have worked with our judges and with our probation and parole officers to ask them what they feel they need. And certainly as the judge was saying here, they need options that do not require detention, and those are the community-based services to refer children and the families to. Those community-based services need to be evidence-based, meaning they should work because they have been proven to work in other settings.

Mr. WAXMAN. Chairman Collins, this has been an excellent panel, and I want to thank all of them for their testimony.

Chairman COLLINS. Thank you. Senator Durbin.

OPENING STATEMENT OF SENATOR DURBIN

Senator DURBIN. Thank you, Madam Chairman. And let me say, there are few committees and few chairmen who would take the time to hold this hearing. It is really unfortunate. But this is an exception, and under your leadership, in this Committee, together with our friend Congressman Waxman, we are talking about a subject which a lot more people should be talking about in the Senate and in the House and across the United States.

If the topic had been that we have discovered through investigation that children were starving at these facilities, subjected to physical abuse, were not properly clothed, were freezing in the winter, I think we would have a bank of cameras against that wall, and it would be on the front page of most papers tomorrow. But

because the underlying issue is mental illness, it is not likely. Why?

Well, I think, frankly, because we as a society view this as a curse or a crime, not an illness. We just have not grown up to accept the reality that it is an illness that can be treated.

And, of course, the Senate has not done much on its own. When Senator Wellstone died, we said one thing we are going to do when we get back is deal with mental health parity, you can bet, in the name and honor of Paul Wellstone. Almost 2 years have passed and nothing has happened. That is a sad commentary on the body that we serve in. We should do more. Senator Domenici has been a leader in this area. Senator Wellstone was. There is a lot more that we can do.

I am struck by a lot of things at this hearing. A lot has been covered so well by the Chairman and Congressman Waxman. But a couple things do stand out here. Why do we have such an increased incidence of mental illness? Some of the statistics among African Americans suggest mental or emotional disabilities are up 77 percent in the last 30 years or so. Why? Why are we running into more of this? Is it because we now know what to look for? It has always been there, we did not know what to do with it before, now we can diagnose it and now we can suggest treatment? But is there something going on in America that has led to this dramatic increase in mental illness, particularly among young people? Is this the beginning of a trend that is even going to be worse in years to come?

Would anybody like to suggest an answer?

Judge GRAY. Well, I think I will be brave. I think there are a couple of things, Senator. You touched on one. I think that now, more than in years past, people are willing maybe to speak up and to say we are having a problem in this area. Many years ago, it was a shame, it was a curse, and so people tried to keep it hidden. I think now people are at a point where they just cannot provide for themselves without going somewhere else to get help.

I do think that, unfortunately, in this country many of our young people are disillusioned about what their futures are in this country. And if you talk about the African American community, they are out of work; they do not see a future; they do not have a hope for a future. And so many of our young people have turned to drugs, and that is a real problem. And, actually, I am not just going to say African American because I think what we see is that drug usage is high among white kids as well. But, unfortunately for African American children, I do not believe that they see a way, that they see a future, and so they are very disillusioned. They are growing up in families where many of their parents are incarcerated, have been incarcerated, are also on drugs. And they are being pushed out of the school systems. You heard about children who are being expelled and suspended. These are the children who are being pushed out of the school systems. And so they go home at night without a hope for tomorrow that things are going to be better. I think that is one of the reasons we are seeing more of these kinds of problems prevalent among our young people.

Senator DURBIN. Mr. Dixon, I liked your father's quote. [Laughter.]

Mr. DIXON. Oh, he was smart.

Senator DURBIN. If I wrote it down correctly, "You cannot cripple a child and then criticize the way he walks."

Mr. DIXON. Right.

Senator DURBIN. And I think that is part of the problem that Judge Gray is pointing to. If we do not get to some of the root causes of this despair and family break-up and dysfunctional situation, then we are going to continue to treat imperfectly the results.

Ms. Carothers, you talked about what happens once these young people reach the age of 18. Has anybody done a study to figure out what happens to them once they have been pushed around in the system through foster care and detention facilities and now, bingo, they are adults out on their own? Where do they go?

Ms. CAROTHERS. I have not seen a study. Anecdotally, through my work with adults, I can tell you that recidivism is enormous and is highly likely if you are in the juvenile criminal justice system for you to be in the adult criminal justice system. And, the numbers of people we have in the adult system speak to that. We have more people incarcerated than any other country anywhere.

But I have not seen any—I could look and send you some recidivism studies if you would like.

Senator DURBIN. I have sat in some of these facilities, some of the better ones. They are despairing that, at age 18, it is as if they have to walk away in my State from a lot of the services and a lot of the help that they could offer to a person just because that age has been reached.

Let me just add, we are about to consider a gang violence bill on the floor of the Senate, and no one supports gang activity and the criminal violence and the terrible thing that is happening. But one of the things that this bill does is shift the burden of whether the accused gang member under the age of 18 is going to be treated and prosecuted as an adult or child. Currently, it is up to the State to argue that this person should be treated as an adult even though they are under the age of 18. The bill flips the responsibility. Now it is up to the young person and his attorney to argue they should be treated as children in the system; otherwise, they will be treated as adults. That is a dramatic change, and it kind of goes to the same argument here when it comes to young people, this mindless "you do the crime, you do the time." We get into this sloganeering here and forget that those are real human beings standing in front of us, some of whom have been victims of the system of our own creation. Thank you, Madam Chairman.

Judge GRAY. Senator, I would say, if I could, in response to your question about the studies, in particular for children who are aging out of foster care, there is quite a bit of information out there about those children who are transitioning out of the foster care system upon their 18th birthday and what life looks like for them. And I would be happy as well to send you some of that material. But what it shows is that those children that we saw are now independent at 18 or in some States 21, they lack the ability to get jobs; they are in the homeless population; they are in the mental health institutions because many of them do have mental health issues that are not being treated. They do not graduate from high school. They are not getting their GEDs, and, therefore, they are

not going on to higher education. Their lives are really not looking very positive when they age out of foster care, and so that is a real concern for those of us in the juvenile area who are dealing with that population of kids every day, trying to figure out what are the safety nets we can put in place for them so that they have a chance to make it in this society when they are no longer cared for by the State child welfare agencies.

Dr. MARTINEZ. Senator Collins, may I respond to Senator Durbin?

Chairman COLLINS. Absolutely.

Dr. MARTINEZ. With regards to your first question about the prevalence or incidence of mental illness among our youth, in our child welfare system we have an overrepresentation of children of color. In our juvenile justice system, we have an overrepresentation of children of color. In our mental health system, we have an underrepresentation of children of color. So when we see the number of children of color being identified as having mental illness going up, in some ways that is a good thing in that we are now screening and assessing and identifying those children better than we ever have before. Once they are identified, hopefully we exercise that professional and ethical responsibility to treat those children. And I think that is a good thing.

I do not necessarily think that there is a higher incidence as there are more children being identified. And, of course, there are many societal factors that play into this, whether it be poverty, poor education, and other societal issues. But we are encouraged to see more numbers of children of color being identified so that we can do something about it.

Chairman COLLINS. Thank you, Senator Durbin.

I want to thank all of our witnesses today. You really enhanced our understanding of the consequences of the tattered safety net that we have for caring for children with mental illness. I want to thank in particular Congressman Waxman for his participation. It has been a great honor to work jointly with you on this. And I really hope that this bipartisan, bicameral approach can make a difference, because what is going on now is absolutely unacceptable. That we are incarcerating children who are ill, who are suffering from mental illness, rather than treating them because there is no place for them to go is a tragedy, and it just called out for our action. And we need a comprehensive approach. We need to pass the Keeping Families Together Act, the Family Opportunity Act, a bill that I have cosponsored with Senator Bingaman to increase the number of mental health professionals for children. But I am sure I can speak for my colleagues in saying that we are really committed, and I want to thank them for their participation today. Thank you so much for sharing your extraordinary expertise and your caring with the Committee.

The hearing record will remain open for 15 days for additional statements and questions. And, finally, I would like to thank Priscilla Hanley of my staff and also Dr. Josh Sharfstein of Congressman Waxman's staff for their hard work. We could not have done it without them.

So thank you, and this hearing is now adjourned.

[Whereupon, at 11:40 a.m., the Committee was adjourned.]

APPENDIX

Testimony of Rep. Henry A. Waxman
"Juvenile Detention Centers: Are They Warehousing Children with Mental Illness?"
Governmental Affairs Committee
U.S. Senate
July 7, 2004

Thank you, Chairman Collins. I commend you for holding this hearing on the unnecessary incarceration of youth who are waiting for community mental health services. And I want to acknowledge your leadership.

Too often, there is little connection between the issues Congress addresses and the real problems facing our nation. When "foreign sales corporations" seek a change in the tax laws — as they are currently doing — hundreds of lobbyists come out of the woodwork, campaign contributions flow like water, and the attention of legislators becomes riveted on arcane provisions that have little relevance for most Americans.

But when there is a crisis in access to children's mental health services, that same sense of urgency is lacking. The problem is real and affects millions of families, yet without corporate lobbyists in the hallways or the prospect of sizeable campaign contributions, the needs of children with mental illness have received little attention.

That's why your long-term commitment to children's mental health is so rare and so extraordinary.

And that is why today's hearing — and the report we are jointly releasing — are so important. I hope we can finally jolt Congress and the Administration into action.

Two years ago, at the request of Senator Jeff Bingaman and Representative Tom Udall, my staff investigated the fate of youth with mental illness in New Mexico who could not obtain care in their communities. What we found was deeply disturbing: One in seven youth in juvenile detention in New Mexico were there solely to wait for mental health services — over 700 youth jailed simply because treatment was not available.

It was apparent to you, Chairman Collins, and to me that these inexcusable conditions were likely to extend beyond New Mexico. So at our joint request, my staff expanded its investigation. We surveyed every juvenile detention facility in the United States. We heard back from more than 500 administrators in 49 states, a response rate of over 75%.

The resulting report is the first ever national study of unnecessary incarceration of children suffering from mental illness.

Here are some of the key findings:

- **Two-thirds of juvenile detention facilities in the United States lock up mentally ill youth because there is no place else for them to go.**

- **Every day, about 2,000 youth are incarcerated simply because community mental health services are unavailable. This represents about 7% of all youth in juvenile detention.**

- **In 33 states, juvenile detention centers hold youth with mental illness who have no charges against them of any kind.**

- **Over 160 detention centers report that youth held unnecessarily have attempted suicide.**

- **Children as young as seven years of age are incarcerated because they do not have access to care.**

Many of the detention centers we surveyed responded with written pleas. A detention center administrator in Louisiana wrote, "We appear to be warehousing youths with mental illnesses due to lack of mental health services." A Washington State administrator said, "We have had a number of juveniles who should no more be in our institution than I should be able to fly."

A Tennessee administrator implored, "The last place some of these kids need to be is in detention. . . . Those with depression are locked up alone to contemplate suicide. I guess you get the picture."

We get the picture – and it is deplorable.

The findings of this report indict how our society treats children suffering from mental illness, in the United States of America, in the 21st century.

The report recalls the 19th century, when reformer Dorothea Dix traveled from jail to jail gathering stories of individuals suffering from mental illness who were abandoned and ignored. Her work led to the creation of the nation's first asylums.

Since the mid-1800s, psychiatry and associated professions have learned to diagnose and treat complicated mental illnesses. Hospitalization is now recognized as a treatment of last resort. It is well understood that many children with mental illness can recover and lead productive lives.

Yet even as scientific knowledge has advanced, our social policy has faltered. We have seen the emptying of psychiatric institutions without the establishment of adequate community services. We have seen the starvation of public budgets that support the basic needs of millions of Americans with mental illness.

Today, the backbone of financing for children's mental health services, the Medicaid program, is in grave danger. Proposals to turn a guarantee of care into block grants for states could seriously compromise what little is left of the safety net.

The findings of this report call on us to reverse course.

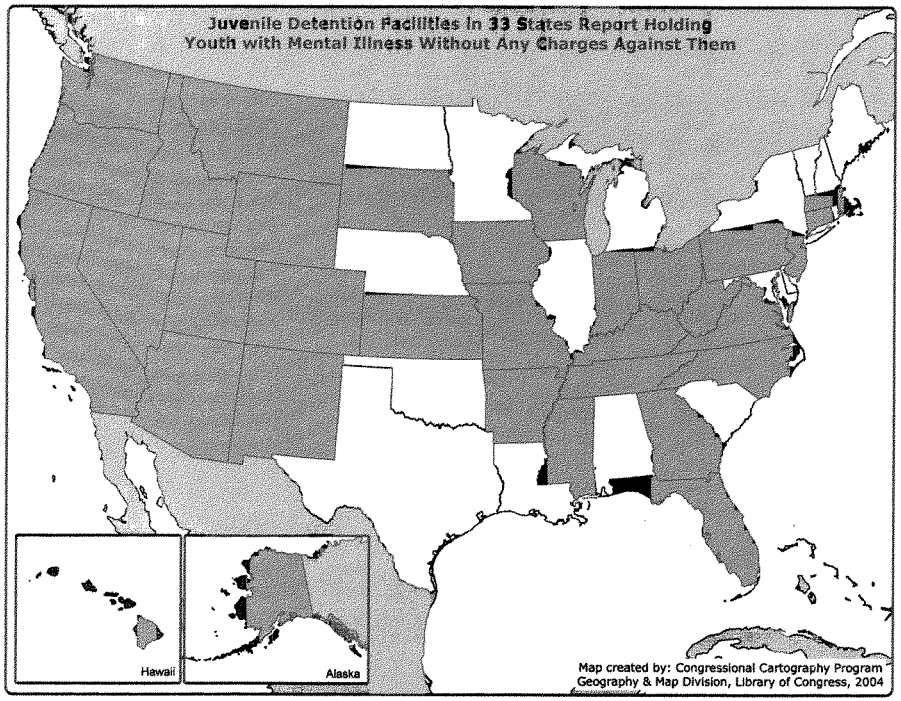
Congress must ensure that adequate mental health services are available to all who need them. We must reform a confusing and bewildering mental health care system so that it works for the benefit of children and their families.

And we must insist upon accountability, so that someone is held responsible each and every time a child is jailed to wait for mental health services.

We must work together — not as Democrats or as Republicans, but as Americans who care about children and their families — to end this warehousing of youth who are in need of treatment.

In closing, let me again thank you, Chairman Collins, for your leadership. I look forward to the distinguished witnesses who will testify about these serious problems later this morning.

In 33 states, juvenile detention centers hold youth with mental illness who have no charges against them of any kind.



Two-thirds of juvenile detention facilities in the United States lock up mentally ill youth because there is no place else for them to go.

Every day, about 2,000 youth are incarcerated in these facilities because community mental health services are not available.

Over 160 detention centers report that youth held unnecessarily have attempted suicide.

Children as young as seven years of age are incarcerated because they cannot access care.

Louisiana: "We appear to be warehousing youths with mental illnesses due to lack of mental health services."

Washington State: "[W]e have had a number of juveniles who should no more be in our institution than I should be able to fly."

Tennessee: "[T]he last place some of these kids need to be is in detention. . . . Those with depression are locked up alone to contemplate suicide. I guess you get the picture."

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM — MINORITY STAFF
SPECIAL INVESTIGATIONS DIVISION
JULY 2004

INCARCERATION OF YOUTH WHO ARE WAITING FOR COMMUNITY MENTAL HEALTH SERVICES IN THE UNITED STATES

PREPARED FOR

REP. HENRY A. WAXMAN AND SEN. SUSAN COLLINS

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The U.S. Surgeon General has found that debilitating mental disorders affect one in five U.S. youth, but access to effective treatment is often limited. This report documents a serious consequence of the health system's failure to ensure effective mental health care: the inappropriate incarceration of youth who are waiting for community mental health services to become available.

Without access to treatment, some youth with serious mental disorders are placed in detention without any criminal charges pending against them. In other cases, such youth who have been charged with crimes but are able to be released must remain incarcerated for extended periods because no inpatient bed, residential placement, or outpatient appointment is available. This misuse of detention centers as holding areas for mental health treatment is unfair to youth, undermines their health, disrupts the function of detention centers, and is costly to society.

At the request of Rep. Henry A. Waxman and Sen. Susan Collins, the Special Investigations Division surveyed every juvenile detention facility in the United States to assess what happens to youth when community mental health services are not readily available. More than 500 juvenile detention administrators in 49 states, representing three-quarters of all juvenile detention facilities, responded. This report, the first national study of its kind, presents the results of the survey. It covers the period from January 1 to June 30, 2003.

The report finds that the use of juvenile detention facilities to house youth waiting for community mental health services is widespread and a serious national problem. The report finds:

- **Two-thirds of juvenile detention facilities hold youth who are waiting for community mental health treatment.** These facilities are located in 47 states. In 33 states, youth with mental illness are held in detention centers without any charges against them. Youth incarcerated unnecessarily while waiting for treatment are as young as seven years old.

  - A Louisiana administrator commented, "The availability of mental health services in this area is slim to none. . . . We appear to be warehousing youths with mental illnesses due to lack of mental health services."

- **Over a six-month period, nearly 15,000 incarcerated youth waited for community mental health services.** Each night, nearly 2,000 youth wait in detention for community mental health services, representing 7% of all youth held in juvenile detention.

  - A Montana administrator wrote, "a majority of the youth held here are warehoused awaiting placement."

- **Two-thirds of juvenile detention facilities that hold youth waiting for community mental health services report that some of these youth have attempted suicide or attacked others.** Yet one-quarter of these facilities provide no or poor quality mental health services, and over half report inadequate levels of training.

  - A Missouri administrator stated, "Youth who are banging their head or fist or feet into walls or who are otherwise harming themselves must be restrained creating a crisis situation. . . . [C]onsequently detention staff have to divert all resources to that one youth for an extended period of time."

- **Juvenile detention facilities spend an estimated $100 million each year to house youth who are waiting for community mental health services.** This estimate does not include any of the additional expense in service provision and staff time associated with holding youth in urgent need of mental health services.

  - A Washington administrator wrote, "We are receiving juveniles that 5 years ago would have been in an inpatient mental health facility. . . . [W]e have had a number of juveniles who should no more be in our institution than I should be able to fly."

While this survey was not designed to assess why so many youth are incarcerated to wait for community mental health services, juvenile detention administrators cite difficulties accessing community residential treatment, inpatient psychiatric care, outpatient mental health care, and foster care services. As an Ohio administrator stated, "Most youth with mental health concerns are housed here whether appropriate or not as there are minimal mental health resources provided . . . for them."

According to experts in mental health and juvenile detention, the survey results likely underestimate the full scope of the problem. Major improvements in community mental health services are urgently needed to prevent the unnecessary and inappropriate incarceration of children and youth in the United States.

I. INTRODUCTION

The Surgeon General has reported that more than one in five U.S. children ages 9 to 17 have a mental or addictive disorder that causes impairment.[1] According to the National Institutes of Mental Health, "no other illnesses damage so many youths so seriously."[2]

While effective therapies for depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, and other conditions exist, families often face difficulties in accessing care. Insurance coverage is often inadequate, and many communities do not have sufficient inpatient, residential and outpatient treatment services.[3] The Surgeon General found that "a high proportion of young people with a diagnosable mental disorder do not receive any mental health services at all."[4]

Inadequate access to mental health care can have severe consequences for children and their families. In April 2003, the General Accounting Office (GAO) reported that at least 12,700 families relinquished custody of their children to the child welfare or juvenile justice systems so that they could receive mental health services.[5] This problem was explored in hearings of the Senate Governmental Affairs Committee,[6] and it is addressed in the Keeping Families Together Act (S. 1704), legislation introduced by Senator Susan Collins and a bipartisan group of her colleagues to assist states in eliminating the practice of parents relinquishing custody of their children solely for the purpose of receiving mental health services.[7]

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1 Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 123 (1999).

2 National Institutes of Mental Health, *Blueprint for Change: Research on Child and Adolescent Mental Health* (2001).

3 President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (July 2003); American Psychiatric Association, *A Vision for the Mental Health System* (Apr. 2003).

4 Department of Health and Human Services, *supra* note 1, at 180.

5 General Accounting Office, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services* (Apr. 21, 2003).

6 Hearings before the Senate Committee on Governmental Affairs, *Nowhere to Turn: Must Parents Relinquish Custody in Order to Secure Mental Health Services for Their Children?* (S. Hrg. 108-169) (July 15 and 17, 2003).

7 The Keeping Families Together Act would provide funding for interagency systems of care for children and adolescents with serious mental and emotional disorders and

A major consequence of the failure to provide sufficient mental health care is the inappropriate use of juvenile detention centers to hold youth with mental disorders. Some youth are placed in detention without any criminal charges pending against them, solely to wait for community mental health services to become available. In other cases, youth with mental illness who have been charged with crimes are incarcerated only because no mental health treatment is available. The misuse of detention centers as holding areas for mental health treatment is unfair to youth, undermines their health, disrupts the function of the detention centers, and is costly to society.[8]

In a previous report in March 2002, the Special Investigations Division examined the problem of incarceration of youth with serious mental disorders in one state, New Mexico. This report found that 13 of 14 juvenile detention facilities in New Mexico incarcerated such youth solely to wait for mental health services to become available. The report also found that one in seven youth in detention was waiting for mental health treatment.[9]

Prior to this report, there was no national study of children and youth who are incarcerated unnecessarily while waiting for community mental health treatment in the United States.[10] To fill this void, Rep. Henry A. Waxman and Sen. Susan Collins asked the Special Investigations Division to conduct a national survey of juvenile detention facilities to determine what happens to youth with mental disorders when community services are not readily available. This report presents the results of a year-long investigation by the Special Investigations Division.

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establish a federal interagency task force to examine mental health issues in the child welfare and juvenile justice systems. The legislation was also introduced in the House of Representatives by Reps. Jim Ramstad, Patrick Kennedy, and Pete Stark as H.R. 3243.

[8] *See, e.g.*, Anne E. Casey Foundation, *Juvenile Detention Alternatives Initiative* (2004) (online at http://www.aecf.org/initiatives/jdai/); National Juvenile Detention Association and Youth Law Center, *Juvenile Detention Center and Training School Crowding: A Clearinghouse of Court Cases* (Aug. 1998); American Academy of Child and Adolescent Psychiatry, *Recommendations for Juvenile Justice Reform* (Oct. 2001).

[9] Minority staff, Government Reform Committee, U.S. House of Representatives, *Incarceration of Youth with Mental Health Disorders in New Mexico* (Mar. 18, 2002).

[10] The General Accounting Office recommended that the Department of Justice track the inappropriate detention of youth with mental illness across the country. However, the Department of Justice declined to do so, writing that "institution of a long-term tracking program appears premature as we currently have no data regarding the true scope of the problem." General Accounting Office, *supra* note 5; Letter from Assistant Attorney General William E. Moschella to the Honorable Tom Davis (July 30, 2003).

II. METHODS

In the spring of 2003, the Special Investigations Division adapted the survey used in its 2002 study of inappropriate detention in New Mexico into a national survey covering the period January 1 to July 1, 2003. The survey requested that detention center administrators provide data about "youth with mental illness who do not need to be in detention." Specifically, the survey asked for data about any youth "waiting for mental health services in the community, including placement in a treatment facility . . . [who] leave the detention center as soon as appropriate treatment services become available."

In the summer of 2003, the survey was reviewed by experts in the fields of mental health and juvenile justice, including state juvenile justice officials recommended by the American Correctional Association.

In late August 2003, the Special Investigations Division mailed the survey to administrators of 814 facilities identified by the American Correctional Association as possible providers of juvenile detention services. A second mailing was completed in October 2003, and one followup phone call to nonresponding facilities was made in November 2003. From the initial list, the Special Investigations Division identified 698 facilities providing secure juvenile detention services.[11]

To estimate the expense of incarcerating youth who are waiting for mental health services, the Special Investigations Division used per-capita cost data from the American Correctional Association.[12] An average per-capita cost was calculated based upon available data and then extrapolated to the total number of unnecessary days in detention.

For the purposes of this report, the term "juvenile detention" refers to the holding of youth age 21 and under in secure correctional facilities in three settings: (1) without charges; (2) pre-adjudication; or (3) immediately post-adjudication. It does not refer to the juvenile prison system, where youth who are convicted of crimes go to serve their sentences. "Community mental health services" refers to

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[11] Those facilities that were not counted in the final list of 698 juvenile detention facilities included: (1) facilities that no longer exist; (2) entries that were duplicate; (3) facilities that do not provide juvenile detention; and (4) juvenile detention facilities that are not secure.

[12] American Correctional Association, *National Juvenile Detention Directory 2003–2005* (2003).

mental health services that are available outside of the juvenile justice system, including inpatient hospitalization, outpatient services, residential treatment, and specialized foster care.

III. FINDINGS

A. Three-Quarters of Juvenile Detention Facilities Responded to the Survey

Of 698 juvenile detention facilities identified in the United States, 524 responded to the survey (75%). Responses were received from every state except New Hampshire and from all regions of the country (Table 1). Responding facilities included 196 located in rural areas, 191 in urban areas, and 131 in suburban areas.[13]

Table 1: Response Rate of Juvenile Detention Facilities by Region

Region	Responding Facilities	Total Facilities	% Responding
Northeast	58	71	82%
Midwest	147	184	80%
South	183	269	68%
West	136	174	78%

B. Two-Thirds of Juvenile Detention Facilities Hold Youth Who Are Waiting for Community Mental Health Services

Three hundred and forty-seven juvenile detention facilities (66%) report that their facilities hold youths who do not need to be in detention as they wait for mental health services outside of the juvenile justice system. These facilities are located in 47 states — all except New Hampshire (where no facilities responded

[13] Six facilities did not respond to the question.

to the survey), Delaware (where three facilities responded), and Rhode Island (where one facility responded).

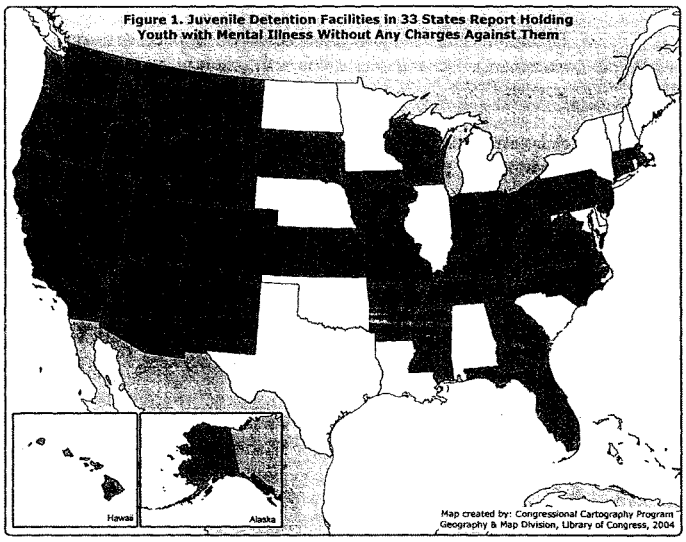
Detention center administrators report the unnecessary use of detention for youth with mental illness in all regions of the country, and in rural, urban, and suburban settings (Table 2).

A Louisiana administrator who submitted written comments with the survey described the problem as follows: "The availability of mental health services in this area is slim to none. We have had to detain and monitor closely juveniles who are acutely depressed/suicidal due to lack of bed/space at the state mental health facilities. We appear to be warehousing youths with mental illnesses due to lack of mental health services."

Table 2: Juvenile Detention Facilities Holding Youth Who Are Waiting for Community Mental Health Services, by Region and Setting

Region	Facilities Holding Waiting Youth	Responding Facilities	% Holding Waiting Youth
Northeast	45	58	78%
Midwest	97	147	66%
South	110	183	60%
West	95	136	70%
Setting			
Rural	119	196	61%
Urban	138	191	72%
Surburban	87	131	62%

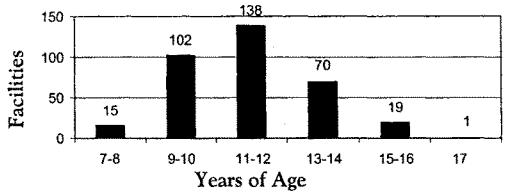
The legal status of incarcerated youth who are waiting for services varies. Two hundred and sixty-one facilities hold youth waiting for community mental health services prior to their adjudication; 229 hold such youth after adjudication. Seventy-one juvenile detention facilities in 33 states report holding youth with mental disorders without any charges against them (Figure 1). In one such facility, a Georgia administrator stated simply, "No other place would accept the child."



C. Children as Young as Seven Years Old Are Incarcerated while Waiting for Mental Health Services

Juvenile detention facilities frequently hold young children because of the absence of community mental health services. One juvenile detention facility reports holding a 7-year-old child, 117 juvenile detention facilities report holding children 10 years and younger, and a majority of detention facilities report holding youth under 13 years of age (Figure 2).

Figure 2: Youngest Age of Youth Waiting for Mental Health Services in Detention



D. In a Six-Month Period, Nearly Fifteen Thousand Youth Waited in Detention for Community Mental Health Services

Administrators from 280 facilities were able to provide quantitative data on the number of children and youth with mental illness who were waiting for community mental health services. These data indicate that 14,603 youth were incarcerated at these facilities while waiting for mental health services from January 1 to July 1, 2003, representing 8% of the total number of juveniles held by these facilities (181,865).

The narrative comments of detention center administrators illustrate the magnitude of the problem:

- A detention center administrator from Oklahoma wrote, "To put it simply we are the dumping grounds for the juvenile system. Understand this and understand it well: when the system is unable to get youth placed in a treatment facility or a mental health facility, they will be placed in a detention facility. If a youth needs to be detained in a mental health facility it will not happen; they will be placed in a detention center."

- A California administrator commented, "We are overwhelmed by the sheer number of mentally challenged youth that we must deal with. We have become the depository of last resort for all acting out, behaviorally challenged, developmentally disabled [youth] when others don't know how to handle [them]."

Youth who are held while waiting for treatment stay longer than the general population of juvenile detainees. Detention center administrators report that youth who are waiting for services stay an average of 23.4 days in detention, versus 17.2 days for all detainees.[14]

Assuming an even distribution of unnecessary stays in detention, this means that on any given night, there are 1,903 incarcerated youth waiting for community mental health services. On any given night, these youth represent 11% of all youth incarcerated at these facilities (347,419 total person-days out of a total of 3,128,283) and 7% of all youth at all responding facilities.

According to the detention centers, this is a growing problem:

- A Montana administrator commented, "I feel that a majority of the youth held here are warehoused awaiting placement."
- A Pennsylvania administrator commented, "This juvenile detention center . . . has become not only the most expensive mental health ward for youth in the county, I believe that it admits more youth with mental problems than any other facility in the county. . . . Mentally ill youth placed in juvenile detention facilities stress our centers more than any other problem I know."
- A Washington administrator wrote, "We are receiving juveniles that 5 years ago would have been in an inpatient mental health facility. . . . [W]e have had a number of juveniles who should no more be in our institution than I should be able to fly."

E. Two-Thirds of Juvenile Detention Facilities That Hold Youth Waiting for Community Mental Health Services Report That These Youth Have Attempted Suicide or Attacked Others

Of 347 facilities where youth are held while waiting for community mental health services, 168 facilities (48%) report suicide attempts among these youth. One hundred and ninety-five facilities (56%) report that these youth have attacked others. In total, 241 facilities (69%) report either suicide attempts or aggressive behavior by youth waiting for mental health services.

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[14] Administrators from 252 detention facilities were able to provide data on this topic.

These episodes can be very difficult for detention facility personnel. For example:

- An Arkansas administrator wrote, "We've experienced juveniles of this sort attack other juveniles, staff. Throw feces, urine, spit, smear feces on walls and themselves. We are not equipped to handle these juveniles."

- A Georgia administrator commented, "Residents who await mental health treatment create an unsafe environment for themselves, other residents, and staff."

- A Missouri administrator wrote, "Youth who are banging their head or fist or feet into walls or who are otherwise harming themselves must be restrained creating a crisis situation. . . . [C]onsequently detention staff have to divert all resources to that one youth for an extended period of time."

- A New York administrator explained, "When youths are made to wait for placement, they become hostile and threatening to staff and sometimes assaultive towards staff."

- A Pennsylvania administrator recounted, "We have had mentally ill residents try to hang themselves, to mutilate themselves (even with pencil erasers), to smear feces and urine in their rooms, on roommates, on staff, throw food, attack staff, attack other residents, refuse to shower or bathe."

F. Detention Facilities Are Generally Not Equipped to Provide Adequate Care to Youth with Mental Illness Who Are Incarcerated while Waiting for Treatment Services

Juvenile detention administrators report that incarcerated youth who are waiting for community mental health services suffer from a range of serious mental disorders, including depression (noted in 315 facilities), substance abuse (315 facilities), attention deficit hyperactivity disorder (302 facilities), retardation and learning disorders (234 facilities), and schizophrenia (137 facilities). Other conditions noted by administrators among children unnecessarily incarcerated include anorexia nervosa, post-traumatic stress disorder, and autism.

Many administrators do not feel that their facilities are equipped to provide care to youth who are inappropriately detained. Of the 347 facilities that held youth waiting for services, 95 (27%) report poor, very poor, or no mental health treatment for youths in detention.

Even when treatment is available, the staff is often ill-equipped to handle the youth. Of the 347 facilities that held youth waiting for services, 187 (54%) report that staff receive poor, very poor, or no mental health training. As a North Carolina administrator commented, "This population is very difficult to manage due to staff not being trained adequately to deal with mental health issues." A Tennessee administrator wrote, "Upon admission we screen for mental illness, but the only training we've received is a seminar."

Juvenile detention administrators also commonly report frustration with the quality of services provided by outside agencies. For example, an Arizona administrator wrote, "The community behavioral health specialist agency does a poor job of working closely with detained juveniles." An Indiana administrator wrote that the local mental health agency "does not have the ability to deal with them on the Inpatient unit. They try to tell us the juveniles would be better off in our facility." A Minnesota administrator commented, "We have very few resources in the state of Minnesota to refer these youths, especially inpatient facilities." And a North Dakota administrator noted, "We have limited time with psychiatric services."

A Texas administrator described a case of an incarcerated youth with "auditory and visual hallucinations and is homicidal/suicidal." The administrator explained what happened:

> We immediately contacted [the mental health department]. They came and did a brief assessment and identified a need for hospitalization. However, we were told it would be at least a month before he could even see the psychiatrist. He was not of top priority because he was in a secure environment. The psychiatrist then refused to see him without a parent present. I explained that the court had placed him in our care . . . . I was told this was my problem. I finally got him into a psychiatrist 45 mins away, because the local [mental health department] was being so difficult. He is now on medication and doing well.

Even when care is available, the juvenile detention facility is not an optimal setting. For example, a Maine detention facility administrator noted, "Due to the high turnover, it is difficult to do long-term treatment."

G. Detention Facilities Spend Nearly $100 Million Each Year to House Youth Waiting for Community Mental Health Services

Incarcerating youth who are waiting for community mental health services is costly. Of the 347 facilities holding youth unnecessarily, per-capita information on cost was available from the American Correctional Association for 163 facilities. The mean per-capita cost at these facilities was $140 per day. These facilities spent an estimated $17.9 million for unnecessary detention in the first six months of 2003. Extrapolating this rate of expense to the total reported number of unnecessary days produces a cost estimate of $48.9 million in the first six months of 2003. On an annual basis, this is a $98.8 million expense.

This calculation does not take into account any additional expenses, such as extra service provision and staff time associated with incarcerating youth with urgent mental health needs.

H. Youth Wait in Detention for a Variety of Community Mental Health Services

The most appropriate setting for treatment of youth with mental health disorders depends on the severity of the disease. Youth with the highest risk of causing injury to self or others require inpatient psychiatric hospitalization. Those requiring close monitoring by professionals can thrive in residential placements, such as group homes. Others can live with their families at home if intensive community-based services are available. Finally, some youths can leave detention once a foster family is located.

While the survey was not designed to determine why so many youths are incarcerated to wait for mental health services, detention facilities across the country report deficiencies in many levels of care. Youth waited for residential treatment in 337 facilities (97%), for inpatient hospitalization in 190 facilities (55%), for outpatient services in 140 facilities (40%), and for foster placement in 161 facilities (46%).

These services can be very difficult to access. For example:

- A Massachusetts administrator commented, "In-patient hospitalization has become extremely scarce. . . . Our staff work diligently to stabilize these clients but their illness calls for a multilateral approach towards treatment, which really is not available in a juvenile detention center."

- A Nevada administrator wrote, "We have limited options for placement. We have a private hospital who can refuse admittance and a state program that is always hard to get admittance, if not impossible."

- A Utah administrator commented, "The facility has to rely on local mental health agency and at times those staff are not available when a need arises. Availability is the biggest problem."

- A Virginia administrator noted, "We feel that we are used as a mental health facility. It isn't unusual for a mental crisis counselor to decide to leave a suicidal child in detention. . . . The waiting list for outpatient appointments is 6–8 weeks. There are very few services for detention."

I. Administrators of Juvenile Detention Facilities Report Frustration with the Incarceration of Youth Who Are Waiting for Mental Health Services

In written comments to the survey, juvenile detention administrators provided descriptions of their experiences incarcerating youth with mental illness who are waiting for community mental health services. These comments overwhelmingly reflect frustration with the current use of detention centers as holding facilities for mental health treatment. A selection of additional comments by administrators can be found in Table 3.

Table 3: Additional Comments by Juvenile Detention Facility Administrators

Colorado	"Budget cuts have affected placements for kids with [mental health] problems. Youth corrections continues to see a rise in mental health kids."
Connecticut	"[C]learly children are being stabilized here when a more therapeutic environment, if available, would be more suitable."
Florida	"It appears that detention is used as a dumping ground for youth with mental health problems that no one else can control."
Georgia	"These youth should be served in a mental health facility not in a detention facility."

Table 3: Additional Comments by Juvenile Detention Facility Administrators	
Iowa	"The problem with our system is the youth cannot be detained in a hospital setting due to their behaviors, while it is unsafe for them and center staff for them to remain in the center."
Kansas	"There [are] clearly not enough resources for these juveniles, with severe problems. Detention has become the catchall for juveniles that nobody wants. . . . Unfortunately juvenile detention centers are not equipped nor funded to deal with this type of population."
Michigan	"Children are entering the juvenile justice system who should be cared for by mental health OR social services solely because [juvenile justice] is long-term care (the wrong kind but still long-term)."
Mississippi	"The two places youth are sent are 50 to 100 miles away. It would be helpful to have something closer to treat the youth. It will be very nice to have a waiting center locally to keep these youth in the proper place, not detention."
Nebraska	"Currently, there are long waiting lists at the majority of our out of home treatment facilities. Therefore, youth sit in detention until an opening is available."
Ohio	"Most youth with mental health concerns are housed here whether appropriate or not as there are minimal mental health resources provided by this state for them."
Oregon	"In our area, detention has become one of the only resources for mental health care for adolescents. . . . This is a very bad situation."
South Dakota	"It is very stressful for my staff to have to constantly watch a juvenile that has a mental illness."
Tennessee	"I find the last place some of these kids need to be is in detention. The kids with conduct disorder end up

Table 3: Additional Comments by Juvenile Detention Facility Administrators	
	being locked in their cell for their actions. Those with depression are locked up alone to contemplate suicide. I guess you get the picture."
Wisconsin	"Things need to change. Too many people of all ages are being held in corrections rather than in mental health institutions where they would receive needed services."

IV. POTENTIAL FOR UNDERESTIMATION

For several reasons, the results presented in this report are likely to underestimate the extent to which youth are incarcerated unnecessarily while waiting for community mental health services:

- One-quarter of secure juvenile detention facilities did not respond to the survey. These detention centers appear similar in geographic distribution to those that responded.[15] Unnecessary detention of mentally ill juveniles in these institutions is not included in the totals presented in this report.

- Among responding administrators, some did not provide usable quantitative data. As a result, these facilities also did not contribute to the totals in this report.[16]

- According to several experts consulted by the Special Investigations Division, other administrators may have been reluctant to report the inappropriate use of their facility out of fear that it would reflect poorly on the detention center itself.

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15 Southern juvenile detention facilities were somewhat less likely to respond to the survey than facilities from other regions (68% versus 79%). Other regions were equally represented.

16 For example, 280 facilities provided usable quantitative data on the number of youth with mental illness waiting for services, and 252 facilities provided quantitative data on the number of days spent by these youth in detention.

V. CONCLUSION

The unnecessary detention of youth who are waiting for mental health treatment is a serious national problem. Detention facility administrators across the country report that thousands of youth with mental health problems are being held unnecessarily in the juvenile justice system. Inappropriate detention is dangerous for youth and the staff of detention centers and is costly to society. Major improvements in community mental health services are urgently needed.

STATEMENT OF CAROL CAROTHERS

OF AUGUSTA, MAINE

ON BEHALF OF NAMI
(THE NATIONAL ALLIANCE FOR THE MENTALLY ILL)

ON JUVENILE DETENTION CENTERS: ARE THEY WAREHOUSING CHILDREN WITH MENTAL ILLNESSES?

BEFORE THE GOVERNMENTAL AFFAIRS COMMITTEE

UNITED STATES SENATE

JULY 7, 2004

Chairwoman Collins, Senator Lieberman, and members of the Governmental Affairs Committee, I am Carol Carothers, the Executive Director of NAMI Maine, the Maine state chapter of NAMI -- the National Alliance for the Mentally Ill.

I am also the proud recipient of a 2004 Robert Wood Johnson Community Health Leadership Award for my work to improve conditions for Maine's inmates living with mental illness and co-occurring substance use disorders.

First, I would like to thank you for providing me with this opportunity to testify today about an issue that is of great concern to me and families across the state of Maine – the warehousing of children with mental illnesses in youth detention facilities.

I have reviewed the report released today titled *The Incarceration of Mentally Ill Youth Waiting for Community Mental Health Services in the United States* -- and can share with you first hand from my experience working in jails and prisons and contacts with youth living with mental illnesses and their families that the findings are accurate. The sad truth in Maine and nearly every other state in our country is that youth with mental illnesses are being held in juvenile detention for the sole purpose of awaiting mental health treatment and services. It is hard to imagine a worse place to house a child that requires healthcare treatment and services for their mental illness. Surely we would not dream of placing a child with another serious illness, like cancer for example, in a juvenile detention center to await a hospital bed or community based treatment. It is outrageous that we do this to children with mental illnesses, as young as 7 years old. This takes an enormous toll on the child and the family.

Rather than only share family stories on this crisis, I would ask you to read a copy of *The Portland Press Herald's* three part series titled *Castaway Children* (August 2002). I have provided copies of this series for the committee and the record. This series tells the compelling stories of how the lack of adequate mental health services in Maine has dramatically impacted many children and families, often with tragic consequences. The

media has reported on similar stories in many other states – and the report released today on incarcerating children with mental illnesses makes clear that the lack of adequate and appropriate mental health services for youth and families is a national crisis.

Children and Families Are Suffering Unthinkable Consequences from This Crisis

My first involvement with mental health and the criminal justice system came in response to the death of an 18 year-old youth with co-occurring mental health and substance use disorders. This young man had fallen though the cracks for years – no one had intervened or properly diagnosed or treated his mental illness or his substance use disorder. Ultimately, he hung himself in Maine's most restrictive prison -- the super-max. The incredible tragedy is that he fits right within the confines of this report – he was in the super-max only because he was suicidal and no hospital bed could be found for him and not because of any offense that he had committed. What an unfortunate loss of a young life, particularly when today we have made great scientific strides in understanding how to properly diagnose and treat mental illnesses in youth and adults.

There have been plenty of other cases with unthinkable outcomes. Recently, Maine settled a lawsuit on behalf of a child committed to the youth center at the age of 13. At that time, he was suffering from depression and suicidal ideation. He was held in isolation for 152 of his first 240 days. Because of the severity of his illness and the lack of proper treatment, this child was committed to a youth center five times and each time this pattern of isolation continued. As one would expect, this child's behavior deteriorated and his symptoms of depression, aggression, and eventually self-mutilation, increased. This led to more periods of isolation as punishment for his poor behavior – he was spiraling deeper and deeper into his illness. A juvenile justice center was hardly an appropriate environment for a child suffering from a serious mental illness.

I spoke to a mother last week, who began her quest for help for her son with mental illness when he was in junior high school. The school system responded to his bipolar illness by insisting that there was nothing wrong with him, refusing to provide special education services, and expelling him when he failed to follow school rules. His mother nearly lost her job because she was frequently absent from work to care for him, and her other children begged her to kick him out of the house. At age 12 when he first entered the juvenile justice system, the courts responded by incarcerating him because they also were not trained to recognize his mental illness nor did they understand the research showing that their approach would make him worse, not better. And the youth center where he was locked up contributed to his down-ward spiral by placing him with older juveniles who taught him advanced criminal behaviors. She said, if I could ask for anything I would ask them – what money did you save by denying my son mental health treatment and services? He could have had a good school experience and would have been thriving now. Instead, the family suffered, he suffered, and I bet it cost significantly more money to treat him in this inhumane manner.

One of the moms in our support group has a 13 year old son who was in a residential school program and doing well. However, she moved north, and her son was supposed to transfer to another program closer to her. The plans to link him to new

services fell apart, and he ended up with nothing -- no psychiatrist, no case worker, no medications, and no therapist. As one would expect, he fell apart and landed in juvenile detention, where he still is, weeks later. And, what's different since he landed there – he NOW cuts himself and has learned negative behaviors that are likely to make his reintegration into the community more difficult – another compelling example of why it is such an inappropriate environment for kids with mental illnesses.

Many moms inform me that they have been told to either give up custody of their child with a mental illness to obtain services or the state will come and take their healthy children away and put them in foster care because of the behaviors of the ill child and the potential for harm caused by the symptoms of that illness. These are parents who love all of their children and have depleted their resources to try to get mental health services – what kind of a choice is that for a parent who loves their child and is desperate to secure services?

Juvenile Detention Centers Are the Worst Possible Environment for Children with Mental Illnesses

In criminal justice facilities the symptoms of mental illnesses are often misinterpreted by inadequately trained staff as disobedience, defiance or even threats. I have seen this first hand. Often well meaning, but untrained corrections' staff, respond to these behaviors with anger, discipline or even force. When staff are allowed to resort too quickly to threats and force in the face of non-compliant adolescent behavior, minor incidents escalate and the risk of harm increases for both the child and the officer. Many of the techniques used in correctional settings -- like prolonged isolation and restraint -- actually lead to increased, not decreased acting out and self-harm, particularly among youth with mental illnesses.[1]

It is wrong to place children with mental illnesses that require treatment into juvenile detention centers where the symptoms of their illnesses significantly worsen and their long-term outcomes become much bleaker. These are environments almost guaranteed to exacerbate their mental illnesses. Children with mental illnesses belong in therapeutic treatment centers. Imagine the message that we are sending to these children when we house them in juvenile detention while they await treatment for their mental illness – it has a dramatic detrimental effect on these children.

Additionally, when a child is housed in a juvenile detention facility, parents experience a complete loss of involvement in their child's life. The philosophy of many detention centers is to limit contact of youth confined to the facility with their families. Families lack the opportunity to stay closely connected to their child at a time when the child is vulnerable and most in need of their love and support.

Juvenile detention centers have limited resources and serve complex populations. When children are detained in juvenile centers in Maine, they are housed in a single unit where 10 year olds can be housed with 20 year olds. This makes educating the child and providing for their individual needs extremely difficult. It also creates vulnerability of

[1] Remarks of Steven Rosenbaum, Special Litigation Section, U.S. Department of Justice. May 16, 1999.

these younger children to physical and sexual assaults and victimization. Staff frequently spend most of their time protecting vulnerable kids from predatory kids, especially when the unit houses far more youth than they are built to house.

Finally, if youth housed in the center have undiagnosed mental disorders, which many do, then the correctional setting is slow to respond, complicating matters and leading to a deterioration in mental status, increased violations of rules, and increased discipline. The unfortunate reality is that the more experiences that youth with mental illnesses have in juvenile detention centers, the more likely it is that they will descend deeper and deeper into the criminal justice system. The initial placement in juvenile detention becomes a self-fulfilling prophecy.

Maine, Like Most States, Lacks Adequate Home and Community Based Services

Maine, like many other states, lacks anything close to adequate home and community-based mental health services for youth with mental illnesses. This is the case despite the fact that home and community based services cost considerably less than institutional care and keeps children at home or close to home and loved ones. Research shows that serving kids in the community and close to home – whenever possible -- leads to more stable lives and better outcomes and often saves the state money over institutional care. It costs fifty to eighty thousand dollars a year to lock a child up in a detention facility and about $30,000 to provide intensive in-home services for a family for one year.[2]

Families are forced to beg for crisis services or are placed on long waiting lists for services. Families report being told that they must wait as long as one year or more for services. This has led to the unnecessary warehousing of children in juvenile detention centers. The urgency of this crisis cannot be overstated. There is anecdotal and research-based evidence that too many of the youth housed in juvenile detention centers graduate to the adult correctional system. The United States is now the country with the largest number of incarcerated citizens in the world. Four new prisons open every month to house the growing number of individuals that are convicted of crimes.[3]

We are spending money in all of the wrong places. We need to appropriate funds to build home and community based mental health treatment and services for children with mental disorders. This will both benefit society as a whole and lessen burdens on the juvenile justice system.

The failure to adopt new policies and to consider what works will mean that growing numbers of states will spend more on their correctional systems than they do on their treatment or education systems. We must not become a nation that spends more to

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[2] Portland Press Herald Series, *Castaway Children*, August 2002 (citing the Department of Human Services, Department of Behavioral and Developmental Services and Department of Corrections and the publication's databases).

[3] The Road to Return, video. Project R, Breaking the Cycle of Crime. Tulane University, New Orleans, L.A. 2000.

incarcerate children than we spend on their education or in providing them with treatment for their serious illnesses.

Unfortunately, in Maine, like most other states across the country -- mental health and substance abuse services are being substantially reduced, rationed, and eliminated as states struggle to balance their budgets. What this will surely mean is that more children and adults with mental illnesses will be locked up in correctional facilities because they cannot access the treatment that they desperately need. The money cut from mental health and substance abuse services will not be saved, instead it will be shifted to the juvenile and corrections' budgets, a waste of taxpayer money and an inhumane way to treat children and adults with mental illnesses.

What Can Be Done to Help End This Crisis?

Congress can take several steps to address this public health crisis.

First, Congress should enact the Keeping Families Together Act (S. 1704/H.R. 3243) – which is designed to help end the tragedy of forcing families to give up custody of their child to the state to access mental health services. This bill would provide grants to eligible states to develop a more comprehensive array of home and community based services. It also calls for better coordination between child serving agencies – this is desperately needed. Families report that child-serving agencies – like education, child welfare, juvenile justice and mental health – rarely coordinate services, often work at odds and overall fail to work together to help children with mental illnesses and their families. This bill would help end the warehousing of children in juvenile detention centers while they wait for mental health services.

Second, Congress should also enact additional federal legislation to help improve access to essential community based services for youth with mental illnesses and their families. This should include increased funding for the full array of mental health services needed by these youth.

Third, NAMI supports the immediate enactment of The Mentally Ill Offender Treatment and Crime Reduction Act (S. 1194/H.R. 2387). This bill would authorize funding for grants to states and communities to be used in a variety of ways to address the high percentage of youth and adults with mental illnesses locked up in jails and prisons. These include jail diversion programs, community reentry programs, and enhanced treatment for youth and adults with serious mental illnesses who come into contact with criminal justice systems.

Fourth, Congress should enact The Senator Paul Wellstone Mental Health Equitable Treatment Act -- the mental health parity legislation (S. 486/H.R. 953). There are discriminatory caps on nearly all private health insurance plans for mental health benefits. Families are often left with no where to turn when they exhaust these benefits. Families are frequently caught in a "catch 22" situation. They fail to qualify for Medicaid under the strict income limits yet even when they have private insurance coverage, their plan provides for inadequate mental health benefits.

Finally, NAMI supports the Family Opportunity Act (S. 622/H.R. 1811) – which would allow families with children with serious disabilities to buy into the Medicaid program – on a sliding cost sharing basis to provide insurance coverage for essential services.

These important legislative initiatives will help to address the crisis described so vividly in the report released today.

Conclusion

In closing, I would like to thank Senator Collins and Representative Henry Waxman for their leadership in presenting this report on incarcerating children with mental illnesses in juvenile detention while they await treatment.

I would also like to share with the committee that in preparing my remarks for this hearing, I spoke with families, inmates, and advocates and asked them -- what is the most important thing that I should say? The answer that they all agreed on -- make sure they understand the urgency of this issue. This is truly one of the major crises facing America today.

Children represent a fraction of the population in our country, but are 100% of our future. Ending this inhumane crisis will require immediate action at every level of government – federal, state and local. Thank you again for this important opportunity to share my concerns. NAMI looks forward to working with you on this and related issues.

Sources

Portland Press Herald/Maine Sunday Telegram, *Castaway Children: Maine's Most Vulnerable Kids*, August 2002.

Out of Luck & Behind Bars:

The Unnecessary Incarceration of Children and Youth Who are Awaiting Community Mental Health Treatment and Supports

TESTIMONY

OF

TAMMY SELTZER
SENIOR STAFF ATTORNEY, BAZELON CENTER FOR MENTAL HEALTH LAW

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

JULY 7, 2004

Background

On any given night, nearly 2,000 children and youth—some as young as seven years old—languish in juvenile detention facilities across the country because they cannot access needed mental health services. As a result, corrections staff struggle to serve a population they are ill equipped to handle, and they and children needlessly risk injury—all at unnecessary taxpayer expense.

Until now, public-policy circles have largely ignored the issue. Recently, however, Representative Henry Waxman (D-CA) and Senator Susan Collins (R-ME) commissioned the first national survey of children with mental health needs unnecessarily incarcerated in juvenile detention centers awaiting treatment. Their findings—released today—highlight a tragic and expensive public policy failure.

Let me take a moment to highlight some the key findings. Over a six-month period in 2003, nearly 15,000 incarcerated youth—roughly 8% of all children in the centers surveyed—were detained awaiting mental health services in the community, according to the survey. Many have no criminal charges pending, while others were arrested for minor offenses, such as truancy or trespassing, generally traced to their mental health problems. Worse, investigators noted that the survey probably underestimates the scope of the problem.

Investigators found that juveniles with mental or emotional disorders also stay in detention 36% longer—an average 23.4 days, compared to 17.2 days for all detainees. Living in a punitive and traumatic setting—with very poor mental health services or none at all—their mental health worsens over time.

The rate of self-harm and suicide among juveniles with emotional and mental disorders while incarcerated is four times that of youth overall. Although the issue of victimization was not explicitly addressed in the survey, these incarcerated youth may also be more likely to be victims of violence by other detainees because they appear more vulnerable due to their illness.

Correctional officers are often overwhelmed trying to serve a population they have few resources and little training to help. When officers restrain children for fear that they will hurt themselves or assault others, the children are at risk of severe injury, even death. Attention paid to youth with serious mental health needs diverts resources from monitoring the other juveniles in detention centers.

Incarcerating youth who are waiting for mental health services is not only damaging to the youth; it is also wasteful. Investigators found that this failed policy cost taxpayers almost $100 million in 2003 alone.

My testimony today will address the causes of this tragedy, describe the kinds of services and supports necessary to keep children with emotional and behavioral disorders out of

the juvenile justice system, and outline steps the federal government can take to make a difference for these children and their families.

Cause of the Crisis: Access to Care

According to detention center administrators, these children they identified for the survey should not be in their facilities and would not be there if appropriate mental health services and supports were available in the community.

Unfortunately, the number of children with mental illnesses who are inappropriately held in short-term detention facilities is just one particularly nasty symptom of a crisis in children's mental health. According to the Surgeon General, about 5-9% of children ages 9 to 17 are affected by a serious emotional disturbance (SED). Yet nearly four out of five American children who could benefit from mental health services do not receive them. The tattered "safety net" for children with mental illnesses drives too many into the juvenile justice system, then leaves them to wait for scarce community mental health services.

Children with mental disorders are funneled into the juvenile justice system through various routes:

- *Lack of access:* In most communities, the public mental health system is open from 9 to 5, when most children are in school, but the police department is open 24 hours a day. The police are the only public employees who have a duty to

respond to every call for help; the mental health system offers too few services and the little they do offer are usually not the kind of intensive, individualized care that we know can prevent children from entering the juvenile justice system.

• *Lack of accountability:* Schools are playing a larger role in sending children with mental disorders to the juvenile justice system. Although legally required to provide positive support and other proactive intervention to address behavioral problems stemming from a student's disability, schools instead invoke zero-tolerance policies and call the police to report even minor violations of school rules.

• *Bias toward law enforcement solutions:* The agencies responsible for supporting parents and treating their children pass the buck by instructing parents to call the police when a child needs help. In one case, a mental health crisis line designed to aid parents called the police rather than send out a crisis team of mental health professionals, even though mental health services would have been a more effective and humane response.

• *Lack of comprehensive insurance for mental health problems:* Desperate parents of a child with a serious emotional or mental disorder often call police when they can no longer handle their child's behavior because their insurance will not cover the mental health services their child needs and the public mental health system offers no help. Parents with no insurance are even less likely to obtain necessary services; parents with Medicaid coverage are not being offered the kinds of services states could provide under that program.

• *Lack of coordination:* The public agencies that serve children (primarily child welfare, education, mental health and juvenile justice) are so uncoordinated that a child can end up with several different mental health diagnoses and each agency referring the parents to another for services that simply do not exist.

What Children Need to Succeed

While model programs are far too rare, effective alternatives to incarceration exist. One such program, Wraparound Milwaukee, works closely with parents to provide services tailored to the needs of each child so children can stay out of crisis and out of the juvenile justice system. The program is reducing costs and—more important—keeping kids out of juvenile detention centers.

Wraparound Milwaukee blends funding from the city's child welfare and juvenile justice agencies and pools it with private and public insurance funds to pay for a coordinated service-delivery system. In its first five years, the program reduced the average monthly cost of care per child from more than $5,000 to less than $3,300.[2] Because the savings were reinvested in the program, Wraparound Milwaukee has been able to nearly double the number of children served. Most important, children's ability to function at home, in school and in the community has improved significantly and the number returning to the juvenile justice system has been cut in half. In addition, Wraparound Milwaukee has been able to return more than 80% of the children in residential treatment centers to their homes or their communities once the children and their families receive the appropriate individualized, strength-based services.

With such blended funding and cross-agency collaboration, other cities and states could improve access to children's mental health services and reduce the number of children who are needlessly and cruelly detained in juvenile facilities.

Fortunately, we know the principles that make programs like Wraparound Milwaukee successful in helping children avoid juvenile detention and succeed in their communities. Children and their families must have ready access to mental health services and supports, and this access must be based on "kid time," not bankers' hours. Services and supports must be designed to enable children to succeed at home and school, not just avoid detention. Child-serving agencies must be held accountable for serving children well and not rewarded for pushing them off of the agency rolls and into the juvenile justice budget. In particular, schools must be responsible for educating and supporting all of their students; communities must not allow schools to shirk their duties by suspending, expelling, and calling the police on students whose behavior could be effectively addressed using positive behavioral supports. In addition, states and the federal government need to do more to end insurance discrimination and to serve the uninsured.

Public Policy Solutions

With blended funding and cross-agency collaboration, other jurisdictions could improve access to children's mental health services. The federal government can also play a role. The Keeping Families Together Act, introduced by Sen. Collins and others, would help reduce the number of children with mental or emotional disorders in juvenile detention

centers by supporting states' efforts to develop coordinated systems of care. The Keeping Families Together Act would provide an essential foundation for reform, but there are also other steps the federal government can take.

Recommendations for Federal Agencies

Department of Justice

According to today's report, in April 2003 the General Accounting Office recommended that the Department of Justice "track the inappropriate detention of mentally ill youth across the country." The Department of Justice declined to follow the GAO's recommendation, citing a lack of information about the problem.

The scope of the problem has now been documented by the Waxman/Collins report, and the evidence shows that the problem is widespread, occurring in two-thirds of the surveyed facilities, and endangering thousands of children with mental or emotional disorders. Courts have found illegal the practice of holding people in detention facilities solely because mental health services are not available. Given the seriousness of the situation, we urge lawmakers to require the Department of Justice to reconsider GAO's request and also encourage the department to enforce the law.

Center for Medicare and Medicaid Services

But simply closing the door to juvenile justice is not a panacea. For example, the report notes that many children are in juvenile justice limbo because of a lack of specialized foster care homes. Obviously, children should be kept at home whenever possible, and

necessary services should be brought to them there. However, when out-of-home treatment is absolutely necessary, therapeutic foster care has proven effectiveness. In therapeutic foster care, a child is placed with specially trained foster parents and provided intensive, individualized mental health services. In addition to helping the child, therapeutic foster care programs also prepare and support the child's family to enable a successful transition after the child leaves the therapeutic placement. This method is less expensive and less restrictive than other types of out-of-home placement, and studies of children in therapeutic foster care show behavioral improvements and more successful transitions to less restrictive environments.[3]

States can use Medicaid to help pay for some of the costs of therapeutic foster care, but far too few states take advantage of this option due to confusion about Medicaid covers. The Center for Medicare and Medicaid Services (CMS) could clear up these misunderstandings by issuing a clarifying memo to state Medicaid directors, thus making more funds available for states to expand the number of therapeutic foster care placements they offer.

Department of Education

In 1997, the Individuals with Disabilities Education Act (IDEA) was amended to include specific language about schools' responsibility to respond proactively to students' behavior if it interfered with their learning or the learning of others. The reauthorization explicitly called for the use of positive behavioral supports and interventions. Research has shown that positive behavioral supports are the most effective way of managing

disruptive behavior for all students, not just those with disabilities. One middle school with 550 students saw a 54 percent reduction of office discipline referrals; 300 fights per year dropped to a handful.[1]

Too few schools have embraced positive behavioral supports, relying instead on zero tolerance policies, suspension, expulsion, and calling the police—tactics that do nothing to improve student behavior, according to experts in the field. In fact, such strategies increase the likelihood that children will end up in the juvenile justice system. From *Pediatrics* journal:

> A Centers for Diseases Control and Prevention study found that when youth are not in school, they are more likely to become involved in a physical fight and to carry a weapon. Out-of-school adolescents are also more likely to smoke; use alcohol, marijuana, and cocaine; and engage in sexual intercourse. Suicidal ideation and behavior may be expected to occur more often at these times of isolation among susceptible youth.[4]

The Department of Education must do more to enforce the IDEA for children with emotional and behavioral disorders and to promote the use of school-wide positive behavioral supports for all children.

Recommendations for Congress

Family Opportunity Act

To address the lack of insurance for families of children with severe disabilities, the Senate should also pass the Family Opportunity Act (FOA). The FOA would allow a

[1] Beach Center on Families and Disability (1998) "School-Wide Positive Behavioral Support Systems A Fact Sheet Developed by the Beach Center on Families and Disability" Retrieved online June 1, 2004 at http://www.pbis.org/english/Schoolwide_PBS.htm

limited group of families who don't otherwise qualify for Medicaid to be able to buy into the program on a sliding-scale basis for their child, improving access to medically necessary mental health services.

Keeping Families Together Act

The Keeping Families Together Act, introduced last Fall by Senator Collins and others, is a specific piece of legislation that would help reduce the number of children with mental or emotional disorders in juvenile detention centers by supporting states' efforts to develop coordinated systems of care.

Treatment for mental health disorders, such as bipolar disorder, depression, schizophrenia, and other serious mental illnesses can be very expensive. Many parents exhaust their private insurance after just a few months and are ineligible for Medicaid or other assistance due to income and assets. This leaves the parents of a child with a severe mental illness with the agonizing decision between care or custody. No parent should be put in the position of making this decision, and no child belongs in the child welfare or juvenile justice system for the sole purpose of obtaining mental health services.

The Keeping Families Together Act will provide states with the ability to build new infrastructure to more efficiently serve children needing mental health services while keeping them with their families in their own homes. This legislation:

- Provides $55 million over six years in Family Support Grants to states that have committed to providing appropriate mental health services to children so that parents

do not have to relinquish custody of their children to get them the help they need. Eligible children and youth are those under age 21 who are in the custody of the state or are at risk of entering care to receive mental health services. Family support services are individualized with family input, provided to the eligible child or youth and their family, and created to promote the mental health of an eligible child or youth;

- Requires collaboration between both private and public partners, including representatives of families of seriously emotionally disturbed children, mental health care providers, private health insurers, hospitals and residential care facilities, as well as state partners, such as the child welfare and juvenile justice agencies among many; and
- Establishes a Federal Interagency Task Force to make recommendations to Congress concerning strategies to improve the delivery of mental health services. The Task Force will work with mental health and child advocates, as well as representatives of affected families and state systems of care to submit a biannual report to Congress on its progress in implementing recommendations, ending relinquishments and improving the delivery of mental health services.

Policymakers should act soon to adopt these reforms. Far too many children with unmet mental health needs are ending up in our juvenile justice system—out of luck and behind bars.

Conclusion

When I last appeared before this committee to discuss parents having to relinquish custody of their children in order to obtain mental health services, I discussed a GAO study that attempted to document the scope of the problem. The most shocking information in the report was not the number of children who had been torn from their families--the 12,700 figure was most definitely an underestimate of the problem. As someone who has worked exclusively in mental health for eights years, I was most troubled about where these children were ending up. I had assumed that the custody relinquishment problem was a child welfare issue. To my surprise, however, two-thirds

of the children were being dumped into the juvenile justice system, while only a third were in child welfare.

Rep. Waxman and Sen. Collins must be commended for requesting this juvenile justice report, which I view as an important follow up to the GAO study on custody relinquishment. The report is yet another indictment of America's failing mental health system. By providing insufficient support to families in crisis and actively involving the police, the public mental health system criminalizes rather than treats mental health problems in children and youth.

We must demand an immediate change in philosophy and expectations. All child-serving agencies must stop using the juvenile justice system to avoid serving children they don't want, and police and judges should refuse to participate in the criminalization of a public health problem. These children languishing in juvenile detention facilities may have been thrown away like yesterday's garbage, but they will be tomorrow's adults. If we do not take responsibility for meeting their mental health needs now, we are undermining their ability to reach their full potential later, and that would be the greatest tragedy of all.

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[1] Katoaka, S.H., Zhang, L., & Wells, K.B. 2002. Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. American Journal of Psychiatry, 159, 1548-1555.

[2] Kamradt, Bruce. 2000 Juvenile Justice Journal.Volume VII, Number 1, April 2000. Retrieved online June 29, 2004 at http://www.ncjrs.org/html/ojjdp/jjjnl_2000_4/wrap.html

[3] U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Washington, DC: Author. Retrieved February 26, 2004, from http://www.surgeongeneral.gov/Library/MentalHealth/chapter3/sec7_1.html.

[4] PEDIATRICS Vol. 112 No. 5 November 2003, pp. 1206-1209. Available online at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/5/1206 The text references Centers for Disease Control and Prevention. Health risk behaviors among adolescents who do and do not attend school—United States, 1992. MMWR Morb Mortal Wkly Rep.1994; 43 :129 –132 and Brooks K, Schiraldi V, Ziedenberg J. School House Hype: Two Years Later. Washington, DC: Justice Policy Institute and the Children's Law Center; 2000.

National Juvenile Detention Association | NJDA

Eastern Kentucky University • 301 Perkins Building • 521 Lancaster Avenue
Richmond, Kentucky 40475-3102 • Telephone: (859) 622-6259
Fax: (859) 622-2333 • E-Mail: NJDAEKU@aol.com • Website: www.njda.com

Testimony of Leonard B. Dixon, Director

Wayne County (MI) Juvenile Detention Facility

Before the United States Senate Committee on Governmental Affairs

"Juvenile Detention Centers: Are They Warehousing Children with Mental Illness?"

July 7, 2004

Testimony by Leonard Dixon
President, National Juvenile Detention Association
Executive Director, Wayne County (MI) Juvenile Detention Facility

Thank you for the opportunity to testify before you today. I am Leonard B. Dixon, President of the National Juvenile Detention Association and Executive Director of the Wayne County Juvenile Detention Facility in Detroit, Michigan. I wish to thank Chairman Collins and Ranking Member Lieberman and Representative Waxman for inviting me here today to discuss with you my views on the report submitted by the Special Investigations Division of the Minority Staff of the House Government Reform Committee titled, *The Incarceration of Mentally Ill Youth Waiting for Community Mental Health Services in the United States*.

The report served to highlight the seriousness of one of the most difficult issues facing all Juvenile Detention Facilities across the nation, and its impact on the daily operation of these facilities across the country cannot be underestimated. In my testimony, I'd like to outline the scope of the problems facing juvenile detention facilities in detaining and caring for mentally ill youth. The problems range from identifying youth with mental illness, accommodating them in our facilities when required, and ensuring that the youth get timely release into mental health placements.

Currently as the Executive Director of a secure detention facility located in Detroit, Michigan, and also having experience at detention facilities in both urban and rural areas in Florida, I have seen first-hand the hopelessness in the faces of youth who are inappropriately placed in secure detention facilities as a means of controlling their behavior.

The corrections community has long been sympathetic to the needs of juvenile offenders with special needs. In 2001, The National Juvenile Detention Association adopted the following position statement, which I have submitted with my written testimony for the record:

> The National Juvenile Detention Association (NJDA) strongly advocates that juvenile offenders with severe mental health issues, who have been identified by a qualified

> mental health professionals, be placed in the appropriate therapeutic environments instead of juvenile detention facilities. When juvenile detention facilities are forced to house youth with severe mental health issues, NJDA promotes the provisions of adequate services by appropriately trained and licensed specialists.

Despite our efforts to ensure that those in need of mental health services do not end up in our custody, parents are often forced to choose the confinement of their child with mental health issues in a detention center as a two-prong solution to a crisis situation: (1) in detention, the child is protected from harming himself, others or destroying the home and property of others, and (2) the family receives a respite while the acting out child is detained regardless of how long the child remains in secure detention. This is done because other options are not available.

Within my facility, social workers and clinicians plead with parents to allow their child with mental health issues to return home, but they are often unsuccessful in their quest for reunification. More often than not, this occurs because families have exhausted all attempts at mental health placements out of the home and the parents are done dealing with the behavior of their children. It also needs to be stated that regardless of the acuity of the situation, long waits in detention for younger children, girls and those with mental health issues are the rule, not the exception.

From May 1, 2003 to May 31, 2004, the Wayne County Juvenile Detention Facility admitted 4,152 youth between the ages of 10 and 17. Of that number, 2,331 were identified as needing and received mental health services. This figures constitutes 56.15% of our 2003-2004-admission population. These figures are reflective of those found in the national report commissioned by Senator Collins and Representative Waxman.

There are several factors within the field of juvenile justice constitute a reasonable argument for ensuring that the inappropriate placement of youth with mental health issues in detention facilities ends. The most compelling argument is that detention for youth is generally short-term and does not include nor guarantee the provision of any type of formalized treatment to address identified disabilities, including mental illnesses. Youth with mental health issues require support and management services that often exceed the level of training provided to the detention staff. These same youth require services that are often not included in operation budgets for detention facilities such as psychological examinations, mental health assessments, specialized units and counseling by licensed clinicians. Despite the limited availability of Medicaid funding for needed services and mental health parity with medical services through insurance providers, demand for resources far exceeds supply placing undue strain on our nation's juvenile detention centers. This prevents juveniles in detention settings from receiving the appropriate services that are specific to each child's needs while detained, with dignity and respect.

A second reason for ensuring that youth with mental illnesses are not detained in juvenile detention facilities is that they are more difficult to manage, more explosive, more easily agitated, require more intensive supervision and create more strain on direct care staff than other youth within a juvenile detention facility. Management of youth with mental health issues results in a higher number of injuries to both staff and youth, the destruction of property with resulting building repairs and an increase in the off-site hospital visits for self-mutilating behaviors, psychotic episodes, suicide attempts, injuries from physical management and fights with other residents. Most juvenile detention facilities do not have the luxury of separating youth with mental health issues from the general population. This creates an atmosphere of conflict and unrest for everyone and the potential for crisis can be very high.

The need for collaboration with mental health agencies in the community is often very difficult, but it is extremely important to the term care of these youth. The most critical reason for the gap in networking on behalf of youth is the lack of coordinated communications between mental health and juvenile justice systems. A youth receiving mental health services can be in custody with detention staff having no knowledge of the youth's involvement in the mental health system. Unless the youth self-reports, the parent reports or the youth has previously been in the juvenile justice system, the detention staff will not be made aware of his or her existing or pre-existing involvement in the mental health system. To add to this problem, oftentimes the records of a youth who has received mental health services in the community, when requested, are not received by the detention facility in a timely manner.

Even when the youth has been identified as a recipient of mental health services, community mental health caseworkers are often unavailable to attend delinquency court hearings with parents on the youth's behalf to substantiate the need for the continuation of mental health services. Lacking the support of caseworkers, the youth often ends up in being sent to secure detention rather than receiving community mental health treatment.

Unfortunately, the majority of youth with mental health needs are housed in secure detention facilities far longer than their counterparts with similar charges and offenses. This is often caused by the inability of community-based mental health providers to provide services to those the court has ordered to be placed in mental health facilities and hospitals. The waiting lists for these type of placements are excessive and the waiting can result in the youth deteriorating, sometimes to the extent that the original placement may no longer be specific enough or applicable to the youth's needs.

One of the most challenging segments of this population, yet one that is not often specifically addressed, is female youth with mental health issues. There is a serious need for specialized services to address the fastest growing population in the field of juvenile justice – girls and youth with mental health issues. Most females entering the juvenile justice system have been physically and sexually abused and require protection from perpetrators, often in their own families. Specialized and gender-specific services for girls are limited and male programs cannot be painted pink to give the impression that they were designed for a female population.

I would like to share with the Committee three stories of youth with mental health issues placed in my facility and the extent to which services were provided and were secured to address the needs of the youth.

The first case involved a sixteen-year old male youth admitted to the detention facility on an assault charge for allegedly stabbing a classmate in the neck with a pencil while experiencing auditory hallucinations. This case illustrates the point that children and adolescents may commit crimęs that are the result of very serious mental illness.

Upon admission, the youth was clearly psychotic and very depressed. He was transferred to a psychiatric hospital where he remained for two weeks. When he returned to detention, he continued to speak about having command hallucinations and paranoid thinking. After staying in detention for several months he was released into the custody of his father who secured a bed for him in a long-term treatment hospital in a neighboring state. While in treatment, his progress was slow but steady. The court ordered a competency evaluation; however, his treating psychiatrists contacted the court's clinic and informed them that the youth was in no condition to travel back to the state for this evaluation.

The judge was not satisfied with this evaluation of the youth and issued a Writ for the youth's return to secure custody in detention. The youth was first housed in a detention center in the same state as the hospital before being transported back to our facility where he remained for several months. Mental health staff at the detention facility requested that his stay be as brief as possible, but we had no impact on his length of stay. The court finally declared the youth incompetent to stand trial and, luckily, his father was able to return him to the psychiatric hospital for treatment.

According to our Mental Health Director, this youth was diagnosed with Schizoaffective Disorder and had a parent who had been diagnosed with Schizophrenic Disorder. A youth with this type of disorder needs intensive mental health treatment, not incarceration. If they are awaiting adjudication, they must be cared for in a forensic setting with extensive mental health services. It was very fortunate that this youth was in a detention facility where a wide array of mental health services, including a mental health unit, to support the youth and keep him from deteriorating during the time it took his legal case to be resolved in court were available.

The second case involves an eleven-year old female youth admitted to the detention facility on a charge of domestic assault because she and her mother were fighting with each other. According to our Mental Health Director, this case is an example of very young children entering the juvenile justice system because families are not given adequate support in the mental health system. This youth has a long history of emotional problems that began in early elementary school, and several members of her family have been diagnosed with Bipolar Disorder. Her mother had suffered with depression in the past.

At age eight, she was hospitalized in a psychiatric facility for the first time because of aggressive behavior toward her mother. Before entering the juvenile justice system, she had two more inpatient psychiatric hospitalizations. She was involved in therapy and was placed on several different types of psychotropic medication; still she began to develop anxiety about school and then flatly refused to attend. The attendance officer pressed her mother to have her regularly attend 5th grade classes at her elementary school, yet the youth refused to attend school.

Because of her mental health history and anxiety upon admission, the youth was admitted to the Mental Health Unit of the juvenile detention facility. At first, she was tearful, frightened and somewhat oppositional. As time went on, she became more comfortable and compliant. It was very apparent to the mental health team that her difficulties were related to her relationship with her mother and would be best addressed in family therapy.

Although the referee had set a low bond for her release, her mother refused to pay it and take her daughter home to "teach the child a lesson." The youth remained in detention for six weeks before a review hearing was scheduled and her mother allowed her to return home. The youth was returned to our facility in less than five weeks because her mother told the court that her daughter was refusing to follow directions. She remained in detention for an additional 3 months as she awaited placement with mental health services.

In this case, the mother needed to have the child out of her house in order to regain control. Yet, the mental health system was unable or unwilling to assist her. This family should have been engaged in outpatient therapy and the detention system should not have been used to separate the child from her mother.

The third case is a clear example of a child who began in the foster care system and was placed in a detention center when his behavior began difficult to manage. It involves a fifteen-year old male youth who entered foster care when he was nine years old because of abuse and neglect. The youth had never returned home since that time. He had been in and out of a detention facility at least eight times, beginning at age ten, because of aggressive, explosive behavior that led to charges of malicious property damage or felonious assault against him. He has been hospitalized two times at a long-term psychiatric hospital, has been in many residential facilities contracted with the foster care system and has been tried on numerous psychotropic medications. During his journey, he learned that he could exit a community mental health placement by becoming aggressive because this would return him promptly to a detention facility – a place that he refers to as "home."

During his last stay at our facility at Christmas, he was very depressed and began to engage in self-mutilating behaviors. As a result he was placed on constant watch, supervised by one staff member. Yet, somehow he managed to find tiny slivers of broken glass in a room where another youth with mental health illness had broken a glass earlier in the day. He told the detention staff that he had swallowed a piece of glass and was sent to the emergency room. From there he was transferred to a psychiatric hospital for treatment of his depression. After a three-day stay, he pulled the fire alarm that opened the locked doors of the hospital and he escaped.

He had planned all along to go back to his old neighborhood to look for his family. He managed to elude the authorities for several months and visited with relatives before being apprehended and returning to our facility. Upon his return, he was disillusioned about his family and sadly reported that he felt unconnected to them.

He has been in detention for more than three months now and is still waiting to be sent to a placement suitable to his plethora of needs in addition to his extensive history of aggressive behaviors. To date, he continues to explode intermittently with staff and peers and has recently begun to refuse his psychotropic medication.

The Foster Care System has not been able to access placements managed by the mental health system. This youth has exhausted a long list of foster care placements that have not had the fortitude or clinical skill to provide him with consistency and stability. Consequently, this youth has learned how to get back to the detention system where he regards the staff and peers as family and has developed some very anti-social behaviors in the process.

In closing, I offer the following recommendations to the committee:

1. All youth should be assessed for mental health issues by a qualified, trained, licensed mental health professional prior to detainment in the juvenile justice system.

2. Detention facilities for youth must have ready access to mental health service providers to ensure the needs ~~of the over 40 to 50 % of their population who~~ require mental health services are able to access them.

3. State mental health systems must develop a seamless system of care to track youth with mental health issues and to ensure that youth are considered for least restrictive placements. In particular, placements for young children must ensure that youth enter the system at the needed level of care.

4. Child and adolescent psychiatric hospitalization must be made available and accessible to families at the time of the crisis helping to ensure that detention facilities are not used as treatment facilities.

5. Community mental health agencies and service providers should be local and accessible to families, even in rural communities. Respite services; transportation and after-hour appointments must be available upon request of the family;

6. Residential facilities should provide a wide array of specialized services for complex populations including abuse/neglect, aggressive/explosive, and sexual victims/perpetrator.

7. Gender-specific services for girls must be developed to address the multi-layered problems underlying their delinquent behaviors.

8. Systems, to include foster care, juvenile justice, child welfare, mental health and education, must unite to provide a system of care to address every aspect of the youths' development.

9. Medicaid and other funding sources identified for youth services must follow the youth and not become available only when the youth enters the system at a designated level of care. Special emphasis must be placed on mental health parity with medical services for our most valuable resource – our youth.

Currently before Congress are two bipartisan proposals that merit consideration and swift approval which would help to fill the gap between treatment and detention. The Keeping Families Together Act, introduced by Senator Collins and others, would help reduce the number of children with mental or emotional disorders in juvenile detention centers by supporting states' efforts to develop coordinated systems of care. The Mentally Ill Offender Treatment and Crime Reduction Act would help to promote collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems in diverting individuals with mental illness from the criminal and juvenile justice systems and would promote treatment within those systems.

I thank you for your time and hope that this issue remains at the forefront of your consideration and that positive change is forthcoming in the very near future.

TESTIMONY OF ERNESTINE S. GRAY, CHIEF JUDGE, ORLEANS PARISH JUVENILE COURT, NEW ORLEANS, LOUISIANA

Good morning, my name is Ernestine S. Gray and I have served the Orleans Parish Juvenile Court in New Orleans, Louisiana as a Judge for over 19 years. My nearly 20 years of experience has given me a wide base of knowledge and understanding in the area of Juvenile Justice. I have served on many boards and commissions regarding juvenile issues, specifically serving as a member and past president of the National Council of Juvenile and Family Court Judges. I am pleased to have been invited here this morning to present testimony at this hearing on "Juvenile Detention Centers: Are They Warehousing Children with Mental Health Illness?"

At the outset, I want to thank Representative Henry A. Waxman and Senator Susan Collins for their attention to this issue. It is long overdue.

In preparation for this morning's testimony I have had the opportunity to review the report: The Incarceration of Youth with Mental Illness Waiting for Community Health Services in the United States, the 1999 U.S. Surgeon General's report on Mental Health, S.B. 1704, and information from the National Mental Health Association.

No one can doubt that there is a serious issue as it relates to the mental health of our children and an equally serious issue with the way we provide treatment -- when and if treatment is provided.

My own experience and from everything that I have read on this issue indicates that thousands of children are inappropriately detained/incarcerated in order to receive treatment and because no other less punitive resources are available and the fear is that without such confinement the children may seriously hurt themselves and/or other persons. I know from my work in the National Council that many of my colleagues from around the country have had similar experiences.

All of my experience over the past 19 years is consistent with the findings of the report being released here today. All to often, children charged with delinquent behavior are identified early on as needing mental health services; however, because the services are not available the children are sent back home until there is another violation. Many times it is only after several brushes with the law, when everyone is fed up, that the child is incarcerated in order to get the mental health services.

However, the untold story, as recounted by many of the persons interviewed for this report, is that virtually none of the detention centers or other facilities are designed and/or equipped to effectively meet the needs of these children. The findings of the report while shocking, in my opinion, present a very accurate picture of the real life situation of children who are detained or incarcerated while waiting for mental health services in the community.

Judges are very frustrated by not having appropriate options to meet the needs of the individual children who are present before them in court. It is a terrible miscarriage of justice to detain or incarcerate children in order that they might be able to have a chance at getting any mental health services. This is a widespread problem that cuts

across both the delinquency and dependency cases. Children who have been neglected or abused, many times end up incarcerated because they cannot otherwise get the services they need.

Status offenders, children who runaway, are truant, or ungovernable and unruly, many with mental health issues, are detained/locked up "for their own good" -- because that is the only way Judges think that they can keep them safe.

I have reviewed S.B. 1704 and happy to see legislation being considered. However, given the extent of the problem in most of the 50 states, I am concerned that the scheme set up for funding is on a competitive grant basis. I would much rather see a system that ensures funding for children who need the services regardless of whether an identified state entity or agency is able to write a grant that gets funded.

A problem that I see, which has not been addressed, is the lack of sufficient numbers of child psychologists and psychiatrists. In many communities, as validated again from the survey, there are not people who have been specially trained to work with this delicate population of children. Working with medical school and universities we need to develop the capacity to substantially increase the number of persons who have been specially trained to work with vulnerable children.

Finally, I would like to make a few recommendations on how juvenile justice and mental health systems can work together. These recommendations include:

- 24 hours availability of services

- Standardized screening and assessment

- Better communication coordination interagency/intersystem

- Community-based programs

Integrated treatment across systems (child welfare, juvenile justice, mental health, special education, substance abuse, etc.)

The services that need to be assured for these children include prevention early identification and intervention, assessment, out-patient treatment, home-based services, wrap-around services, family support groups, day treatment, residential treatment, crisis services and inpatient hospitalization.

No matter how hard we try, it will not always be possible to treat all children outside of detention. Nonetheless, these children need treatment for their mental health disorders. In order to effectively serve this population, the juvenile justice system and the mental health system must work together to develop programs and services for these children. These services need to be appropriate for the child's age, gender and culture, individualized and family-focused.

I thank you again for the opportunity to discuss this issue with you and I know that the juvenile and family court judges of this nation are profoundly interested in this work and are willing to work with you to find solutions that improve the lives of these children and families.

State of New Mexico
CHILDREN, YOUTH AND FAMILIES DEPARTMENT

BILL RICHARDSON
GOVERNOR

DIANE DENISH
LIEUTENANT GOVERNOR

MARY-DALE BOLSON, Ph.D.
CABINET SECRETARY

DIANNE RIVERA-VALENCIA
DEPUTY CABINET SECRETARY

Committee on Governmental Affairs
United States Congress
Written Testimony by Dr. Ken Martinez
State Children's Behavioral Health Director
New Mexico Children, Youth and Families Department

July 7, 2004

The Mental Health Needs of Our Juvenile Justice Population:
New Mexico's Approach to Solving the Problem

The National Overview*

Key Point 1: **Growing awareness of mental health disorders among youth in the general population**

- The Surgeon General's 2002 Report on Children's Mental Health found that:
  - ✓ Approximately 20% of children and adolescents in the general youth population are experiencing a mental disorder;
  - ✓ Approximately 10% experience mental illness severe enough to cause impairment at home, in school, and in the community
  - ✓ Yet less than half will receive the treatment that they need.
- The release of the Surgeon General's Report shed light on the fact that mental disorders among youth in the general population were significantly higher than what was previously believed.

Key Point 2: **The prevalence of mental disorder among youth in the juvenile justice system is two to three times higher than among youth in the general population.**

- While the research base on this issue is very much still developing, existing research suggests that most youth in the juvenile justice system, anywhere from 70 to 100%, have a diagnosable mental disorder.

P.O. DRAWER 5160 • SANTA FE, N.M. • 87502
PHONE: (505) 827-7602 • TOLL FREE: (800) 610-7610 • FAX: (505) 827-4053

- Approximately one out of five (20%) has a serious mental disorder.
- Many of these youth are believed to have a co-occurring substance use disorder as well.
- Dr. Linda Teplin at the Cook County detention center in Chicago, Illinois is collecting mental health and substance use prevalence data among youth in the detention center.
    - ✓ Her data suggests that rate of mental disorder are high among both boys and girls (65% to 73% of youth surveyed).
    - ✓ These rates remain high even when you eliminate conduct disorder from the identified disorders- 60% of boys and 70% of girls still meet criteria for some other psychiatric disorder.
    - ✓ Rates of mental disorder are consistently higher for girls than for boys, especially for affective and anxiety disorders.

Key Point 3: **There is an increasing sense of awareness and crisis surrounding the care and treatment of youth with mental disorders in the juvenile justice system.**

- This is a population of youth whose mental health needs have been neglected for a long time.
- Now, attention is being paid in a way that was largely absent ten years ago.
    - ✓ There is growing concern on the part of both the juvenile justice and mental health systems over the criminalization of mental illness. This is a trend that we've seen at the adult level for some time, and are now beginning to see if at the juvenile level as well.
    - ✓ There is increasing attention by the media, advocacy organizations (National Alliance for the Mentally Ill (NAMI), Federation of Families), and funding organizations (private foundations like MacArthur and Annie E. Casey), as well as federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Juvenile Justice Delinquency Prevention (OJJDP).
    - ✓ The Department of Justice is investigating conditions of confinement of youth in juvenile detention and correctional facilities across the country. These investigations have consistently highlighted the lack of appropriate screening, assessment and treatment available to youth, the inappropriate use of medication, and the inappropriate responses to suicide threats.

Key Point 4: **There are a number of factors that are contributing to the sense of crisis.**

- There appears to be an increasing number of youth with mental disorders entering the juvenile justice system. The Texas Youth Commission reported a 27% increase in the number of youth with mental disorders entering the state's juvenile justice system between 1995 and 2001.

- Many of these youth are incarcerated for minor, non-violent offenses. A review in Louisiana found that 73% of youth in Louisiana were incarcerated for non-violent offenses. A similar review of Texas found 67%.

- There is concern that the juvenile justice system is becoming the system of "last resort" for many youth. A 1999 survey by the National Alliance for the Mentally Ill (NAMI) found that 36% of their respondents reported having to place their children in the juvenile justice system in order to access mental health services that were otherwise unavailable to them. A more recent study conducted by the U.S. General Accounting Office (GAO) found that in 2001, parents placed over 12,700 children into the child welfare or juvenile justice systems in order to access mental health services.

Key Point 5: **Despite this, we are seeing signs of improvement with the availability of new and effective tools and services that are demonstrating real promise for youth involved with the juvenile justice system.**

- We now have screening and assessment tools that have been specifically designed for use with youth in the juvenile justice system. The development of the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2), a 52 item self-report screening tool, and the Diagnostic Interview Schedule for Children (V-DISC), a computer operated, voice-activated diagnostic assessment tool, are being used in numerous states and juvenile justice settings across the country. (The MAYSI-2 is being used in 45 states and in 28 of those states being used system-wide (including New Mexico within the correctional facilities). The V-DISC is now in 15 states with plans for expansion, including into New Mexico.

- We now have improved psychosocial approaches, such as cognitive behavioral therapy and dialectical behavior therapy that are both showing tremendous promise.

- Increasing use of evidence-based practices, such as Multisystemic Therapy (MST), Functional Family Therapy (FFT) and the Chamberlain Model of Treatment Foster Care (TFC), which are family and community based interventions. Numerous reviews have consistently found positive outcomes associated with their use with youth in the juvenile justice system:

- ✓ Reduced long-term rates of re-arrest
- ✓ Improved family functioning and school performance
- ✓ Decreased substance use and psychiatric symptoms
- ✓ Reduced rates of out of home placement
- ✓ Significant Cost Savings (Washington Institute for Public Policy Reports)

- While not "evidence-based', we have seen the development of promising interagency collaborative models involving the mental health and juvenile justice systems including:

  - ✓ System of Care models that target youth in the juvenile justice system such as WrapAround Milwaukee and Project Hope
  - ✓ Diversion collaboratives such as New York State's PINS Diversion program and Texas' Special Needs Diversionary Program
  - ✓ Partnerships with universities such as the Prime Time program in Seattle involving the University of Washington and King County.

  *Source: National Center for Mental Health and Juvenile Justice

The New Mexico Experience

For a more local perspective, the following information describes some of the work being accomplished in New Mexico.

County Initiatives

From 1991 to 1999, the Bernalillo County Juvenile Detention Center (BCJDC) housed 130-140 clients ages 8-18, with an average length of stay of 33 days each.

In mid-1999, with the assistance from the Annie E. Casey Foundation, delegations from New Mexico visited best practice sites in Oregon, Sacramento and Chicago. Through that collaboration and the ongoing support of Annie E. Casey, the Bernalillo County Juvenile Detention Center (BCJDC) managed to accomplish several things. The BCJDC now has:

- An average daily census of 65, down from 140;
- With an average length of stay of nine (9) days, down from 33 days, including the Serious Youthful Offenders (SYO);
- An average number of bookings of 3100, down from 5000;
- A recidivism rate of 13%, down from 46%;
- Cost for secure detention per bed day was $96.37 (FY 03) and the cost of the current Community Custody program per day is $19.59;
- 73% of currently detained clients have at least one mental health diagnosis.

How was that accomplished?

- The Children, Youth and Families Department (which has children's behavioral health, juvenile justice services and child welfare), the Human Services Department (Medicaid State Agency), the Department of Health (licensing), Bernalillo County, the University of New Mexico Health Sciences Center, the three Medicaid managed care organizations (MCOs), children's court judges all collaborated, culminating in the Children, Youth and Families Department (CYFD) licensing the BCJDC as a "Children's Community Mental Health Center" which allowed for Medicaid billing of all medical and behavioral health services provided by BCJDC staff for non-adjudicated youth, University of New Mexico contracted child psychiatric staff and other providers. Since it opened in 2002, the Children's Community Mental Health Center has seen 1200 children.

- BCJDC has a relationship with a local adolescent shelter care provider to be its "Reception/Assessment Center" in lieu of detention for minor offenses that are frequently mental health or substance abuse related. Police take juveniles that are picked up to the Reception/Assessment Center for mental health/substance abuse screenings and evaluations to determine their behavioral health needs and either provide those services themselves or refer to other community providers. A second one is planned for the west side of town later this year.

- Two social workers are stationed in Albuquerque Police Sub-stations and in two in Sheriff Sub-stations to work with the youth and their families. Usually, the social worker is able to work with the family on a short-term basis or connect them with needed resources.

- The BCJDC operates a Youth Reporting Center on its campus that is open 7 days a week from 8 am to 8 pm offering academics, recreation, workshops, etc.

- The BCJDC operates a Community Custody Program to supervise youth at job sites, schools, etc.

- The BCJDC is currently working with the one of the Medicaid managed care organizations to develop a tiered program that includes:

    - Case management services;

    - Intensive home based services;

    - Transitional Living Unit-15 bed capacity with anticipated funding from a Medicaid managed care organization for eligible clients released from detention to receive mental health and substance abuse screening, assessment and treatment;

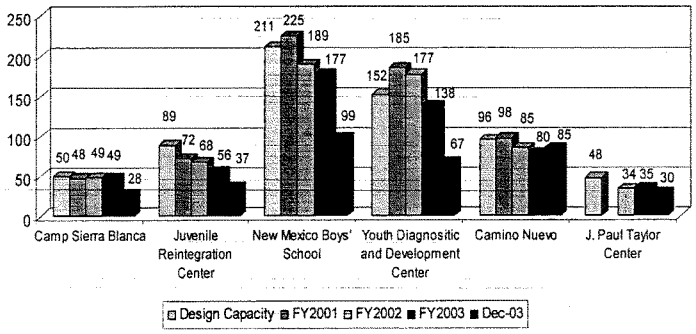
    - Drug and Alcohol and Mental Health Outpatient treatment tracks.

State Initiatives

- In addition to the Bernalillo County initiative, the Children, Youth and Families Department's Juvenile Justice Services has worked closely with the New Mexico Juvenile Parole Board to parole technical violators and low risk clients, with low to high needs who are then referred to community programs to obtain behavioral health services in their local area.

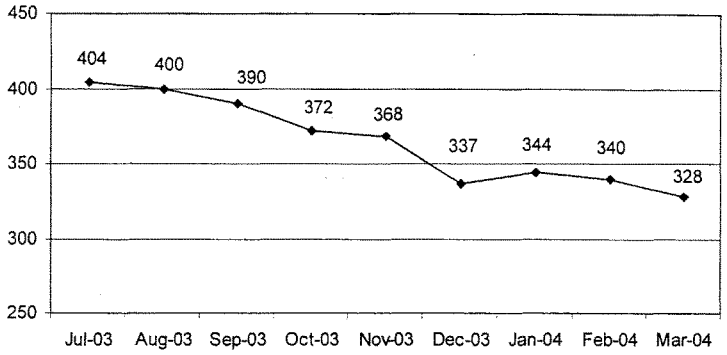
- CYFD has reduced its statewide correctional facility census from 625 to 310, a decrease of 50%. Consequently, the 96 bed maximum security correctional facility closed on July 1, 2004. These reforms have been as a result of many factors including juvenile detention reform at the county level, juvenile drug courts, re-education of juvenile probation and parole officers, law enforcement, juvenile court judges and attorneys.

Table 1**
Capacity and Average Daily Population for
Juvenile Justice Services Correctional Facilities: FY01, FY02 and FY03



Source: Juvenile Justice Services

Table 2**
Average Daily Population of Juvenile Justice Services Correctional Facilities
July 2003 to March 2004



Source: Juvenile Justice Services

Between FY99 and FY03, there was a 47.5 percent (329) reduction of juveniles being committed to Juvenile Justice Services correctional facilities (Table 3 below).

Table 3**
Number of Juveniles Committed to a State Correctional Facility by County
and the Percentage Change From FY 99 to FY 03

County	FY99	FY03	% Change	County	FY99	FY03	% Change
Bernalillo*	186	126	-32.3%	McKinley*	14	10	-28.6%
Cantron	0	0	NA	Mora	2	0	-100.0%
Chaves	29	8	-72.4%	Otero*	29	13	-55.2%
Cibola	1	7	600.0%	Quay	4	4	0.0%
Colfax	6	8	33.3%	Rio Arriba*	12	5	-58.3%
Curry	40	10	-75.0%	Roosevelt	12	6	-50.0%
DeBaca	0	0	NA	San Juan*	92	36	-60.9%
Dona Ana*	35	24	-31.4%	San Miguel	21	13	-38.1%
Eddy	32	19	-40.6%	Sandoval*	16	14	-12.5%
Grant*	13	6	-53.8%	Santa Fe*	13	8	-38.5%
Guadalupe	3	0	-100.0%	Sierra	5	3	-40.0%

Harding	0	0	NA	Socorro	11	0	-100.0%
Hidalgo	3	3	0.0%	Taos*	8	0	-100.0%
Lea	59	15	-74.6%	Torrance	3	5	66.7%
Lincoln	12	7	-41.7%	Union	0	0	NA
Los Alamos	0	2	100.0%	Valencia*	16	5	-68.8%
Luna*	15	6	-60.0%	Totals	692	363	-47.5%

*Counties that implemented Juvenile Drug Courts in 2000.
Source: CYFD FACTS Database

Table 4**
Number of Juveniles Referred to Juvenile Probation and Parole Officers by County and the Percentage Change From FY 99 to FY 03

County	FY01	FY03	% Change	County	FY01	FY03	% Change
Bernalillo*	9,774	9,280	-5.1%	McKinley*	1,622	1,060	-34.6%
Cantron	19	20	5.3%	Mora	36	60	66.7%
Chaves	1,565	1,202	-23.2%	Otero*	1,067	978	-8.3%
Cibola	419	293	-30.1%	Quay	248	243	-2.0%
Colfax	305	252	-17.4%	Rio Arriba*	691	672	-2.7%
Curry	991	960	-3.1%	Roosevelt	188	179	-4.8%
DeBaca	52	24	-53.8%	San Juan*	1,554	1,561	0.5%
Dona Ana*	2,226	2,250	1.1%	San Miguel	709	709	0.0%
Eddy	889	939	5.6%	Sandoval*	1,331	1,057	-20.6%
Grant*	524	328	-37.4%	Santa Fe*	1,501	1,688	12.5%
Guadalupe	88	76	-13.6%	Sierra	233	189	-18.9%
Harding	3	8	166.7%	Socorro	327	349	6.7%
Hidalgo	87	54	-37.9%	Taos*	463	400	-13.6%
Lea	1,121	1,082	-3.5%	Torrance	221	304	37.6%
Lincoln	268	278	3.7%	Union	45	27	-40.0%
Los Alamos	79	95	20.3%	Valencia*	951	778	-18.2%
Luna*	435	422	-3.0%	Totals	30,032	27,817	-7.4%

*Counties that implemented Juvenile Drug Courts in 2000.
Source: CYFD FACTS Database

The CYFD data indicates that the commitments to state correctional facilities and referrals to Probation and Parole Officers reflect that the counties that implemented Juvenile Drug Courts in 2000 all had decreases in Juvenile Justice Services commitments to state correctional facilities and all but three (Dona Ana, San Juan and Santa Fe) had decreases in referrals to Juvenile Probation and Parole Officers.

It is also important to note that as of March, 2004, 69 percent of the 330 juveniles committed to Juvenile Justice Services correctional facilities had at some point received services through child welfare.

- With the estimated savings of $4.9 million from closure of the maximum security facility July 1, 2004 and the reduction of beds at another correctional facility, CYFD is redeploying 41 frozen vacant positions to provide "front-end" behavioral health community based services including Functional Family Therapy (FFT) and Multisystemic Therapy (MST) as well as enhanced client supervision;

- JJS regional coordinators will identify and develop programs and services needed in rural and urban communities;

- The Annie E. Casey Foundation is funding New Mexico to replicate the Bernalillo County model in seven (7) other communities across the State.

Conclusions and Recommendations:

The solutions are not simple. They involve cross-system solutions. There is an obvious blurring of roles and responsibilities of child serving systems, and that is a good thing, because no longer is a child or youth exclusively a child welfare client or exclusively a juvenile justice client or a mental health client. They are the same child or youth in more than one system. They are all our children and youth regardless of the system door they enter.

We in the New Mexico juvenile justice, mental health and child welfare systems applaud you Senator Collins and your colleagues for introducing Keeping Families Together Act. It not only will provide funding for interagency systems of care for children and adolescents but it acknowledges the cross-system complexity in defining the problem and in defining the solution. For too long our child serving systems have not worked together and therefore have missed opportunities to collaborate, share resources such as joint planning, program development and human and financial resources. We have failed to function as either one child serving system or as a coordinated and collaborating set of jointly responsible and responsive child serving systems. Keeping Families Together Act would be one major step forward in promoting cross-system collaboration and it certainly compliments the New Freedom Commission Report on Mental Health that also advocates for more and effective cross-system collaboration to meet the mental health needs of our children and youth.

Both in New Mexico and at a national level there is much more that needs to happen.

- We as policy makers need to recognize that meeting the behavioral health needs of our juvenile justice population in detention is critical.

- Many of the youth detained are in for relatively minor offenses. Diversion programs need to be developed and we need to advocate for, and fund more, community-based treatment options that will provide mental health and substance abuse treatment to these youth in their communities and give judges options other than incarceration. The research suggests that this is the most effective approach.

- While we're doing a better job at screening and assessment, we need to advocate for and fund universal screening for all youth entering detention and provide evaluations and treatment when necessary in appropriate community based settings.

- Community re-entry programs for youth transitioning out of detention and correctional placements need to be strengthened to maximize success and reduce recidivism in both the detention system and restrictive mental health settings.

**Tables from "Children, Youth and Families Department: Review of Juvenile Justice Services June 11, 2004" Report to the New Mexico Legislative Finance Committee

TESTIMONY SUBMITTED OF THE NATIONAL COUNCIL ON DISABILITY

submitted for the hearing record of the U.S. Senate Committee on Governmental Affairs "Juvenile Detention Centers: Are They Warehousing Children with Mental Illness"

Washington, DC
July 7, 2004

The National Council on Disability (NCD) is an independent federal agency with the responsibility for making recommendations to the President and Congress on issues affecting 54 million Americans with disabilities. NCD is composed of 15 members appointed by the President and confirmed by the U.S. Senate. NCD's overall purpose is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, regardless of the nature or severity of the disability; and to empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.

In light of your recent hearing on "Juvenile Detention Centers: Are They Warehousing Children with Mental Illness?" and for the record, we offer the following research information. One of the most challenging issues that NCD has focused its policy work on has involved mental illness and juvenile justice. NCD's work that informs the issue before the Senate Committee on Governmental Affairs includes: (a) the Executive Summary and Chapter 3 on Youth from "The Well Being of Our Nation: An and (b) the Executive Summary from Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: Status of Evidence-based Practices ."

The excerpted material NCD is submitting for your July 7th hearing record is contained on the following pages.

The Well Being of Our Nation:
An Inter-Generational Vision of Effective
Mental Health Services and Supports
National Council on Disability
September 16, 2002

Executive Summary

At a time when more is known about mental illnesses than at any other time in history and just three years after the U.S. Supreme Court held that unnecessary institutionalization violates the Americans with Disabilities Act, public mental health systems find themselves in crisis, unable to provide even the most basic mental health services and supports to help people with psychiatric disabilities become full members of the communities in which they live.

This report does not aim to be a comprehensive review of all that is known about public mental health and its shortcomings. That undertaking has been begun by the U.S. Surgeon General, in the massive 1999 report entitled *Mental Health: A Report of the Surgeon General* (http://www.surgeongeneral.gov/library/mentalhealth/home.html), and will be carried on with President Bush's New Freedom Commission on Mental Health, which held its first public hearings in July 2002. Rather, this report examines some of the root causes of the crisis in mental health, and seeks to "connect the dots" concerning the dysfunction of a number of public systems that are charged with providing mental health services and supports for children, youth, adults and seniors who have been diagnosed with mental illnesses.

One of the most significant findings of this report is that children and youth who experience dysfunction at the hands of mental health and educational systems are much more likely to become dependent on failing systems that are supposed to serve adults. In parallel fashion, adults whose mental health service and support needs are not fulfilled are very likely to become seniors who are dependent on failing public systems of care. In this fashion, hundreds of thousands of children, youth, adults and seniors experience poor services and poor life outcomes, literally from cradle to grave.

There is no single antidote for the current dysfunction of the public mental health system. Clearly, visionary leadership, adequate funding and expansion of proven models (including consumer-directed programs) are essential ingredients. More than these, however, there needs to be a dramatic shift in aspirations for people with psychiatric disabilities.

Public mental health systems must be driven by a value system that sees recovery as achievable and desirable for every person who has experienced mental illness. Systems also must commit to serving the whole person, and not merely the most obvious symptoms. In other words, mental health systems will have to develop the expertise to deliver not just medication and counseling, but housing, transportation and employment supports as well.

There are proven models of success throughout the country, but entrenched forces and stale thinking have prevented them from "going to scale" to serve more people with psychiatric disabilities. Some such models are referenced throughout the report, and Chapter 6 provides a menu of concrete actions to bring about a new vision of public mental health services and supports.

Chapter 3
Impact on Children and Youth

1. Crisis Focus

As is well documented elsewhere,[10] children with emotional disturbance experience significant gaps between the systems of care designed to serve their needs and to support them with their families and in the community. Due to the stresses of poverty, children and youth from low-income families are disproportionately represented among young people diagnosed with emotional disturbance. While this labeling theoretically entitles children to a wide range of services and supports, these are often not delivered. In addition, the labeling itself may serve to reinforce a view of these children as dysfunctional, and relegate them to segregated settings. Public policy must seek to reduce this stigma while delivering supports and services (including naturalistic supports, such as mentoring, after-school programs and improved housing).

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 20 percent of all children from birth to 17 years of age suffer from a diagnosable mental, emotional or behavioral illness.[11]

According to SAMHSA, approximately 7 million children had a diagnosable mental disorder in 1997. Between children and adolescents aged 9 to 17, SAMHSA estimates 2.1-4.1 million (five to 13 percent) have a mental or emotional disorder that seriously impairs their functioning in day-to-day activities.

America's youth is the human resource capital of America's future. The value of these human resources is incalculable. We cannot define or put a value on the loss incurred when today's children and youth with emotional disturbance are damaged in their formative years by systems' failures to provide needed mental health care and/or special educational services. For example, children who lack these services often cannot utilize the free and appropriate public education to which they are entitled under federal law. Children with unrecognized or untreated emotional disabilities cannot learn adequately at school or benefit readily from the kinds of healthy peer and family relationships that are essential to becoming healthy and productive adults.

Many young people with emotional disturbance are already involved in the juvenile justice system.[12] Rates of emotional disturbance among youth in the juvenile justice system have been estimated at 60-70 percent. A significant percentage of the 100,000 youth detained in correctional facilities each year suffers from serious mental disabilities and a commensurately large percentage suffer from addictive disorders. Seventy-five percent of the youth in the juvenile system have conduct disorders and more than half have co-occurring disabilities.

According to a 1999 report by Substance Abuse and Mental Health Services Administration, when compared with adolescents having fewer or less serious behavioral problems, adolescents with behavioral problems such as stealing, physical aggression, or running away from home were seven times more likely to be dependent on alcohol or illicit drugs.

While major mental illness, such as schizophrenia, is often evident only when the individual reaches the late teens or early twenties, there is little doubt that many other disabilities found among the adult prison population surfaced at a much younger age--and went untreated.

The failure to identify (and treat) emotional disturbances is also associated with the growing problem of teen suicides and/or suicide attempts. If properly implemented, Medicaid's EPSDT screening program should assist parents of youth with emotional disturbance and school

personnel in identifying their disabilities, providing the appropriate treatment, and preventing suicide.

The lack of home- and community-based services has still other negative consequences. The lack accounts for unnecessary hospitalization of children and youth with emotional disturbance. It also contributes to readmission. For lack of services that might ease the transition from hospital to home, including respite services for their families, these children cycle back and forth between hospital and the community without ever achieving stability. In turn, unnecessary hospitalization usurps the limited resources of state mental health budgets, thus obstructing the provision of services that might have prevented institutionalization and perpetuating an unproductive cycle.

If all aspects of the system--from assessment to treatment--took into account the long-term needs of children, rather than episodic or crisis occurrence, children's needs would be described in terms of their underlying issues and in the context of their family and living situation instead of mere documentation of short-term behavior or services available. For some children, the system must be prepared to make a commitment to serve the child for their entire childhood, with easy entry and re-entry into the system. Outcome measures should reflect long-term goals--such as school attendance, living at home with family or independently, and working at a job.

Missed Opportunities for Prevention

Poor treatment by the system as a child or youth increases the likelihood of encountering other dysfunctional systems as an adult. Children with serious emotional disturbance have the civil right to receive services in the most integrated setting appropriate to their needs.[13] They further have the human right to be raised in their families and communities, with their individual needs guiding the service array provided. These civil and human rights are embodied in the Americans with Disabilities Act (ADA).[14]

The failure to identify and treat mental disabilities between children and youth has serious consequences, including school failure, involvement with the justice system and other tragic outcomes. As outlined in the Adult chapter, below, adults with mental illnesses who find themselves in the criminal justice system are significantly more likely to have grown up in foster care, under custody of a public agency or in an institution.

There are large discrepancies between the mental health needs of children and youth and the services they actually receive. A recent study found that only one in five children with emotional disturbance used any mental health specialty services, and a majority received no mental health services at all. This is consistent with an earlier finding by the Office of Technology Assessment (OTA) which estimated that only 30 percent of the 7.5 million children who needed mental health treatment received it. However, children with serious emotional disturbance often do not receive the services to which they are entitled under the Individuals with Disabilities Education Act (IDEA).

Individuals with Disabilities Education Act: IDEA has long been the primary vehicle for securing mental health services and supports for children and youth with mental, emotional or behavioral disabilities. The Act's basic tenet is that, until age 21, children and youth are entitled to "a free and appropriate public education." Under IDEA, children with emotional or behavioral

disabilities that interfere with their ability to learn are entitled to special education services, including any related mental health services and supports that enable them to benefit from their education. Yet despite the intent of this strong federal entitlement, parents and advocates report that children are not receiving many of the promised and needed services. Children and youth with emotional and behavioral disabilities are the least likely to receive the services and supports mandated by IDEA.

The 1997 IDEA amendments mandated that school systems provide two new services to address the needs of children and youth with behavioral problems that interfere with their learning or the learning of those around them. Schools must conduct "functional behavioral assessments" (FBA) to determine the causes of undesirable behavior and develop "positive behavioral interventions and supports" (PBIS) to address them. According to Robert Horner, Ph.D., of the University of Oregon faculty,

"research conducted over the past 15 years has demonstrated the effectiveness of strategies that foster positive behavior for individual students and for entire schools. Even schools with intense poverty, a history of violence and low student skills have demonstrated change in school climate when effective behavioral systems have been implemented."

Despite this history of success, parents and school personnel report that schools are not implementing the provisions of the 1997 IDEA amendments. Some profess they don't understand the statute; others are ignoring or actively subverting the law. In almost all cases, it is apparent that school personnel are unaware of how effective (and relatively inexpensive) these interventions can be.

EPSDT and Medicaid: Medicaid-eligible children should also benefit from the early screening required under the Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) mandate and a generally broader array of services in state Medicaid plans than is available in the private sector. Under EPSDT, all states must screen Medicaid-eligible children, diagnose any conditions found through a screen and then furnish appropriate medically necessary treatment to "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services."[15]

Children and youth up to age 21 have a broader entitlement than adults who qualify for Medicaid. For adults, some services are mandatory, but some need only be provided at a state's option. A state will list its "optional" services in its Medicaid plan, but must make available to children all services listed in federal Medicaid law "whether or not such services are covered under the state plan."[16] Few states have good tools to identify children with mental health needs and most fail to monitor providers or health plans to ensure that children receive behavioral health screens.

Medicaid's EPSDT program, especially when used in conjunction with IDEA, is the ideal vehicle for meeting the comprehensive mental health needs of children and youth. The program requires that states conduct regularly scheduled examinations (screens) of all Medicaid-eligible children and youth under age 22 to identify physical and mental health problems. If a problem is detected and diagnosed, treatment must include any federally-authorized Medicaid service, whether or not

the service is covered under the state plan. If problems are suspected, an "inter-periodic" screen is also required so the child need not wait for the next regularly scheduled checkup.

Child mental health services under Medicaid have undergone considerable change over the past decade. For many years, states had included more comprehensive mental health benefits for adults than for children and youth. After the enactment of legislation requiring coverage of all Medicaid-covered services for children through the Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate in 1990, states began revising their rules and expanding coverage of child mental health services.

Shortly after these revisions began to occur, states also began to move the Medicaid population in need of mental health care into managed care, generally into separate "carved-out" specialized managed behavioral health care plans. By 1998, 54 percent of Medicaid beneficiaries were enrolled in managed care programs.[17]

(Health Care Financing Administration, 1998). Due to the rapid expansion of covered services early in the 1990s and the subsequent introduction of managed care, it is pertinent to question whether children and youth actually receive these community-based services and to determine the patterns of service use. Key stakeholders continue to cite the lack of attention to the special needs of children and youth as the most serious problem with the public mental health system.[18]

By offering waivers and options Medicaid law also affords states other policy choices that could expand access to mental health services. The Home-and Community-based Waiver allows states to provide alternatives to hospitalization to children with disabilities, including children and youth with emotional disturbance. The waiver allows states to provide various community support services, but only three states have availed themselves of this waiver for children with emotional disturbance. Significantly, however, a recent study indicates that the Medicaid home- and community-based waiver is effective in reducing the incidence of custody relinquishment and institutional placement in the three states where they are in use.[19]

However, Medicaid does not cover all low-income and other children and adolescents who have no access to mental health treatment. Moreover, while the array of covered services is fairly broad, some home- and community-based services are still excluded from coverage under many state Medicaid programs.

Denial and Inaccessibility of Services

Despite the IDEA and EPSDT entitlements, children and youth in many states fall through the cracks of the public systems of care. This happens even in states like California, with well-developed local government infrastructure:

"Despite the integrity of individual programs-and even with the extraordinary contributions of so many individual professionals-incremental efforts add up to less than the sum of their parts. The programs often fall short of providing the right services, in the right way, to the right children at the right time. Year after year, new commitments--even with additional funding--fail to achieve the goals so desperately desired."[20]

Services are often denied not out of malice, but because of the lack of coordination among systems of care and complexity of funding arrangements:

"Funding is restricted by complex rules that encourage communities to forsake those in the path of danger and focus only on those children who are physically bruised and emotionally broken." (21)

Moreover, the criteria that youth must meet before they can receive services can easily be interpreted to deny services.(22) In practice, many states do not have specific definitions of all covered services, so it is likely that many Medicaid-eligible children receive neither the mental health screens nor the mental health treatment to which they are entitled by EPSDT. The shortage of knowledgeable legal advocates virtually ensures that the rights of many children to EPSDT services will not be enforced.

Access to services is limited due to lack of insurance coverage for mental health services and inadequate access to the special education and related mental health services for which children and youth are eligible through IDEA. For example, ten million children and youth lack health insurance and many more are under-insured for mental health treatment and exhaust their benefits. An estimated 30 percent (3 million) of those 10 million are eligible for Medicaid, but their families are unaware that they qualify.(23)

As states have sought to "do more with less," they have also sought out managed care approaches to limiting Medicaid expenditures. Instead of bridging the gap between child-serving agencies, however, states' shift of Medicaid to managed care has stranded even more children with serious mental health needs.(24)

Tragic Consequences for Children, Youth and Society

Custody Relinquishment: Due to lack of community-based services and/or special education services, families of children with emotional disturbance are often faced with the heart-wrenching choice of not receiving adequate mental health services for their children or relinquishing custody of their children in order to qualify for Medicaid. Child mental health advocates and professionals have recognized the issue of custody relinquishment for many years. (25)

Requiring families to give up custody:

traumatizes both children and parents;

limits family involvement in key decisions about their children's mental health, health and educational needs;

undermines family integrity;

unnecessarily burdens public agencies with children who are neither abandoned; nor neglected, but whose families need services and support to raise them at home; and

penalizes families for the state's failure to develop adequate services and supports.

Requiring families to relinquish custody to the child welfare system in order to obtain essential mental health services and supports for their children wastes public funds and destroys families.

Inadequate funding of mental health services and support for children and their families is the major reason families turn to the child welfare system for help. Private insurance plans often have limits on mental health benefits that can be quickly exhausted if the child has serious mental health needs. In addition, many private plans do not provide the home and community-based services and supports that are needed to keep children at home. When their personal funds run out, families are forced to turn to the child welfare system.

Even families whose children are eligible for Medicaid face custody relinquishment. Although many of the needed services are covered, states fail to adequately define their rehabilitation services, to educate providers on how to bill for those services, or to make sure that Medicaid recipients know the array of services to which a child is entitled. When parents then turn to the child welfare agency, the agency often requires--as a nonnegotiable condition for obtaining those services--relinquishment of custody to the state or county. In large part, this is driven by the child welfare agencies' mistaken belief that custody is required in order to draw federal matching funds under the Social Security Act.

Educational System/Special Education/Discipline: Due to the stresses of poverty, children and youth from low-income families are disproportionately represented in the young population with emotional disturbance. The inequities of the neglect of these children by schools and the public mental health system are further compounded by racial discrimination.

The failure to provide early screening and mental health services has meant that as many as 35 percent of students entering school are considered to be at high risk for social and academic failure.[27] Once in school, the failure or refusal to provide IDEA services results in much greater drop out rates for children and youth with emotional disturbance.[28] This has led researchers to recommend a new approach to screening, and to identifying a child's strengths rather than deficits.

In perhaps the classic attempt to blame the victim, school districts that have failed or refused to provide preventive services under IDEA has also led, inexorably, to treating children with emotional disturbance as "discipline problems." In a series of attempts to amend the IDEA over the past three years, Congress has increasingly expanded the authority of school districts to exclude such children and youth from mainstream classrooms.

The techniques for supporting children with emotional disturbance--known broadly as "positive behavioral supports"--in school are well documented.[29] The use of punishment to correct behavior comes with negative consequences such as negative attitudes on the part of students toward school and school staff (which leads to increased antisocial acts and behavior problems). Punishment of children with emotional disturbance is strongly correlated with dropping out of school.[31]

Foster care: The child protective services and foster care system in the United States grew out of efforts by early religious and charitable organizations to serve orphans and "rescue" children and youth from abusive or neglectful families. Today's federally supported foster care system was

created under the Social Security Act of 1935 as a last-resort attempt to protect children at risk of serious harm at home. The law obligated states to assume temporary custody of children whose parents were unable or unwilling to care for them.

By the early 1990s almost half a million children were in the custody of state child welfare systems and the U.S. Department of Health and Human Services estimated that at least one of every 10 babies born in poor urban areas in the '90s would be placed in foster care.[32]

Children with emotional or behavioral disabilities made up 40 percent of the child welfare population and few resources were available for any type of treatment or support services.[33] The steady increase in foster care placements is very troubling. Most children are deeply traumatized when they are separated from their families. Even when their family environment has been dangerous or unhealthy, studies have shown that a child often experiences separation from a primary care giver as a threat to survival.[34]

Family disintegration and allegations of abuse are the most frequent reasons that children are placed in foster care, and these reasons are often rooted in the inability to get mental health services and support for parents and/or children. These findings are documented more fully in the Custody Relinquishment section, above, and are considered further in the Adult chapter, below.

According to the Annie E. Casey Foundation, every year 25,000 young people in foster care turn 18 and leave foster care. This means that young people in state-supervised programs must leave foster care whether or not they have the skills to maintain an apartment, seek and hold a job, or balance a checkbook. Too many 18-year-olds emerge without having had a stable foster-care environment or adequate mental-health services or a quality education. According to one recent study, 12 to 18 months after they left foster care, half of those who left were unemployed and a third were receiving public assistance. Clearly, youths who "age-out" of foster care are among the most vulnerable and the most at risk.

Juvenile Justice: Each year, more than one million youth come in contact with the juvenile justice system and more than 100,000 are placed in some type of correctional facility. Studies have consistently found the rate of mental and emotional disabilities higher among the juvenile justice population than among youth in the general population. As many as 60-75 percent of incarcerated youth have a mental health disorder; 20 percent have a severe disorder and 50 percent have substance abuse problems.[35]

The most common mental disabilities are conduct disorder, depression, attention deficit/hyperactivity, learning disabilities and posttraumatic stress.[36] According to a 1999 survey conducted by the National Mental Health Association (NMHA) and the GAINS Center, mental health problems typically are not identified until children are involved with the juvenile justice system, if at all.

Although African-American youth age 10 to 17 constitute only 15 percent of their age group in the U.S. population, they account for 26 percent of juvenile arrests, 32 percent of delinquency referrals to juvenile court, 41 percent of juveniles detained in delinquency cases, 46 percent of juveniles in corrections institutions, and 52 percent of juveniles transferred to adult criminal

court after judicial hearings. In 1996, secure detention was nearly twice as likely for cases involving black youth as for cases involving whites, even after controlling for offenses.[37]

Many youngsters have committed minor, nonviolent offenses or status offenses. The increase in their incarceration rates is a result of multiple systemic problems, including inadequate mental health services for children and more punitive state laws regarding juvenile offenders. These nonviolent offenders are better served by a system of closely supervised community-based services, including prevention, early identification and intervention, assessment, outpatient treatment, home-based services, wraparound services, family support groups, day treatment, residential treatment, crisis services and inpatient hospitalization.

Intensive work with families at the early stages of their children's behavioral problems can also strengthen their ability to care for their children at home. These services, which can prevent children from both committing delinquent offenses and from re-offending, are most effective when planned and integrated at the local level with other services provided by schools, child welfare agencies and community organizations.

More than one in three youths who enter correctional facilities "have previously received special education services, a considerably higher percentage of youths with disabilities than is found in public elementary and secondary schools."[38]

Many children with emotional disturbance end up in detention facilities as a result of incidents at school and/or because they fail to receive special education and related mental health services. In addition, many juveniles are released from detention facilities without appropriate discharge services, and end up being re-incarcerated.

Young people with emotional disturbance are punished for the failure of systems designed to protect them. Because schools fail to identify and serve youth with emotional disturbance, these children miss out on much or all of the "free and appropriate public education" to which they are entitled under the federal Individuals with Disabilities Education Act (IDEA), even though IDEA funds services for such children.[39]

Although IDEA requires educational plans to be in place prior to a young person's release from juvenile detention, and a well-designed and implemented plan, coupled with connections to the services provided under Medicaid, can mean the difference between a successful transition to home and community or a repeat of the negative cycle that landed the juvenile in detention in the first place, few states implement this requirement. Thus, juvenile offenders with emotional disturbance frequently fail to reconnect with the education system upon their release.

Without the appropriate intervention, students whose behavior could and should be addressed in school are ending up in juvenile detention. Each year over 100,000 youth are detained in correctional facilities. These institutions have been called the "de facto" psychiatric institutions for adolescents with mental health problems because they substitute incarceration for needed treatment. A recent survey by the Pittsburgh Post-Gazette found that 80 percent or more of the residents of Pennsylvania's juvenile detention centers had a diagnosable psychiatric problem. Arkansas and New Mexico reported that 90 percent of their juvenile detainees were on psychotropic medication.

Effects of Welfare Reform: In the implementation of welfare reform, policy makers have to date focused rather narrowly on the needs of the adult recipients. In particular, reform efforts have concentrated on recipients who are relatively well-positioned to enter the workforce, that is, who do not have evident disabilities or special needs. States have declared remarkable success in their initial efforts to reduce welfare rolls, moving off welfare large numbers of individuals and capitalizing on the current demand for workers. Now, states are beginning to face some unanticipated consequences of return-to-work policies particularly on adults with significant problems (such as those who have mental health and substance abuse issues) and on parents whose children have special needs. States are facing the reality that there is a residual population of welfare recipients whose capacities to work are challenged by these problems.

What might easily be overlooked in the debate on welfare reform is that the children of welfare recipients--both those who have already been counted as "successes" and those remaining on welfare due to special needs--may, themselves, have significant problems. Recipients who have successfully returned to work may have marginal work skills and find themselves in low-level jobs. When they have children with serious emotional disturbance, they may be confronted with parental demands that pull them away from already-precarious work situations. For example, school systems are often ill prepared to deal with special-needs children and seek to exclude them from the classroom. Child care centers are often not prepared to handle children with significant behavioral problems and these children may be expelled, creating significant job-related problems for the parent.

Those welfare recipients who have not yet entered the workforce includes significant numbers of individuals with significant problems of their own, such as depression, post-traumatic stress disorder, and chemical dependency. These problems among parents have been identified as risk factors for emotional disturbance among their children. The movement of these adults into the workforce, which is already a formidable goal, may pose new problems for their high-risk children. For example, children with serious emotional disturbance who have been reliant on parental care and supervision within the home may, for the first time, be entering child care arrangements outside of the home. These settings must be prepared to offer special approaches appropriate to the needs of these children. In addition, it is likely that the workplace success of recipients who are already struggling to overcome their own problems will be compromised by the added stress of disruptions in their children's functioning.

This array of factors suggests that the special needs of children do not simply coexist with welfare reform; parental return-to-work has both an effect upon these children and is affected *by* these children. However, few policies thus far have considered the interaction of welfare reform and recipients' children with serious emotional disturbance. Most states have not worked to ensure that the needs of these children are addressed. As the policy and legislative focus comes to be redirected to the hardest to serve welfare recipients (which may well include a significant number of parents of children with special needs), the well being of children will increasingly come to be an issue.

Psychiatric Hospitalization and "Residential Care": Traditionally, the mental health services available to children with emotional disturbance have tended to fall at two ends of a continuum: 1) treatment in a residential facility and 2) individual, usually once-a-week therapy. Yet youth

with emotional disturbance need one or more of a broad spectrum of therapeutic modalities between these two poles. These include ongoing intensive services in their home community and school. Additionally, their families need support services, education and training on how to best handle the youngster and his or her problems.

In many cases, the lack of home-and community-based mental health services results in unnecessary institutionalization. Deprived of services, the condition of many children and youth with emotional disturbance worsens and reaches crisis proportions, leaving commitment to a residential treatment facility as the only option. Though residential treatment centers lack studies supporting their effectiveness, this treatment--which serves a small percentage of youth -- consumes one-fourth the outlay on child mental health.[40]

Referrals to residential treatment facilities--often unnecessary--remove the child far from home and community; sometimes out of the county or even the state for extended periods of time. Moreover, after leaving the hospital, the lack of transitional services and/or intensive in-home services and supports frequently result in children and adolescents cycling from home to hospital and back again without ever achieving stability.

However, effective home- and community-based services--such as in-home services, behavioral aides, intensive case management, day treatment, family support and respite care, parent education and training, and after-school and summer camp programs--do exist. Of these services, the Surgeon General's report found home-based services and therapeutic foster care to have the most convincing evidence of effectiveness.[41]

These services are furnished in partnership between professionals and families, are clinically and fiscally flexible, and individually tailored for each child and family, providing whatever intensity of service is needed. Home- and community-based services build on strengths and normal development needs rather than just focusing on problems, and provide continuity of care. They strive to be culturally competent and involve the family in the child's care. Evaluations of these community-based services have found them to be highly effective, less costly than the alternative residential services and much preferred by families.[42]

[Note: The report is at http://www.ncd.gov/newsroom/publications/2002/mentalhealth.htm]

Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research
National Council on Disability
May 1, 2003

Executive Summary

Overview

This report summarizes and assesses the state of knowledge about children and youth with disabilities who are at risk of delinquency and involvement in, or who have already entered, the juvenile justice system. By highlighting what is known about addressing delinquency and the diverse needs of this population, it aims to inform policy discussions among policymakers, practitioners, and researchers. The report's specific objectives are to examine

- current laws and philosophical frameworks affecting children and youth with disabilities who are at risk of delinquency or are involved in the juvenile justice system;
- the relationship between disability, delinquency, and involvement in the juvenile justice system;
- the factors associated with disability and delinquency;
- current and anticipated delinquency- and disability-related programming targeting children and youth with disabilities who may enter or who are in the juvenile justice system;
- the effectiveness of prevention, intervention and treatment, and management strategies for reducing delinquency and addressing disability-related needs among this population of children and youth;
- barriers and facilitators to implementing effective strategies for helping these children and youth; and
- recommended "next steps" for increasing the scope and quality of knowledge and practice for reducing delinquency among and addressing the disability-related needs of at-risk children and youth with disabilities.

To achieve these objectives, the report provides a systematic, multidimensional review of existing research and includes insights provided by service providers, administrators, policymakers, advocates, and researchers. The report examines a range of interrelated issues to establish a broad-based foundation—a portrait of the "forest"—for understanding what is and is not known about children and youth with disabilities who are at risk of delinquency or juvenile justice involvement or are already involved in the justice system.

The term "delinquency" here refers to violations of law by individuals legally defined as "juveniles." Typically, state laws use specific age ranges (e.g., 10 to 17) as the sole criterion for determining whether an individual is a "juvenile" and thus subject to processing in the juvenile rather than adult justice system. Violations include status offenses (i.e., acts, such as running away from home or truancy, that only youth, by dint of their "status" as juveniles, can commit) and nonstatus offenses (i.e., acts, such as robbery and theft, that would be crimes if committed by adults). For the purposes of this report, a youth is delinquent if he or she has committed a status or nonstatus offense, whether or not the offense results in a referral to court. Youth who are "involved in the juvenile justice system" can include individuals in short-term detention, probation, long-term secure custody, residential treatment facilities, and aftercare/parole.

This report focuses on several groups of children and youth with disabilities: (1) those who have never committed a delinquent act but are at risk of doing so; (2) those who are engaged in delinquency but have not yet become involved in the juvenile justice system; and (3) those who are or have been involved in the juvenile justice system. All three groups by definition are at risk of delinquency and, by extension, involvement (or further involvement) in the juvenile justice system. In each group, the presence of a disability may or may not contribute to delinquency or a greater likelihood of juvenile justice system involvement (e.g., school referrals to juvenile courts); research suggests that both are possibilities. Regardless, federal law mandates that the civil rights of children and youth with disabilities be protected, including receiving special education and other disability-related services. This report therefore examines not only the issue of preventing or reducing delinquency among these different groups but also the provision of required services. The primary focus is on the juvenile justice system. However, schools also are considered because of their potential role in preventing delinquency and referrals to juvenile courts, as well as facilitating transitions from custodial facilities back into communities.

Background

There is a tremendous gap in empirically based knowledge about children and youth with disabilities, especially those who are either at risk of delinquency or involved in the juvenile justice system. This gap covers a wide spectrum of largely unanswered questions involving distinct sets of policy issues. These issues range from the potentially conflicting philosophies underlying existing laws to what is known about effective prevention, intervention, and delinquency management strategies and efforts to ensure that the rights and needs of children and youth with disabilities are addressed. The objectives of this report cover distinct sets of policy-relevant questions that parallel areas in which significant gaps currently exist.

The report asks, for example, to what extent the philosophies of disability law and juvenile justice policies are contradictory or complementary. How, if at all, are disabilities linked to delinquency, and how are disabilities linked to juvenile justice system involvement, irrespective of any possible causal relationship between disabilities and delinquency? Are the causes of delinquency the same for youth with disabilities and those without disabilities?

From the standpoint of policies for reducing the number of youth with disabilities in the juvenile justice system, what exactly is the need for such policies? For example, what is the prevalence of youth with disabilities throughout all stages of the juvenile justice system? If youth with disabilities are overrepresented in the justice system, is this in any way linked to school-based practices and programming? How might the racial/ethnic dimensions of delinquency and juvenile justice processing contribute to a greater involvement of youth with disabilities in the juvenile justice system?

From a related policy standpoint, what exactly is the needs/services gap? What, for example, are the current or anticipated types and levels of programming for youth with disabilities who are at risk of delinquency or who are involved in the juvenile justice system, and how do these levels differ from the demand for them? Regardless of any gap, what are effective prevention, intervention and treatment, and delinquency management strategies for this population? Are federal laws effective in facilitating the identification of and provision of services to them? More generally, what are the barriers to and facilitators of implementing effective strategies for

addressing their needs, and what are the next steps that should be taken to improve knowledge and practice?

The review for this report suggests partial answers to some of these questions. It also reveals that few systematic overviews of these diverse questions have been conducted. Most studies have investigated delimited parts of each question. The present report thus fills an important void by highlighting the wide range of questions and issues that policymakers, practitioners, and others may want to consider as they create and evaluate new programs and policies or pursue specific research agendas.

Findings

The results of the review and interviews are summarized along seven dimensions, collectively addressing the goal and objectives of this report. The overarching finding was that considerably more empirical research is needed. The report documented, for example, that there is relatively little quality research on almost every dimension that was examined, from the prevalence of disabilities at various stages of the juvenile justice system to the levels and impacts of federal efforts to enforce compliance with disability law. However, it also identified many practices and policies that schools, communities, and the juvenile justice system can undertake that may have a significant impact on preventing and reducing delinquency among children and youth with disabilities, and that may help ensure that their disability-related needs are addressed.

The major findings of the National Council on Disability's (NCD) research are as follows:

- Despite calls for greater prevention and early intervention initiatives in schools and the juvenile justice system, there is little evidence that past, current, or proposed laws will suffice to create this change or to overcome the many conflicting perspectives about youth with disabilities or young offenders.
- Any challenges to implementing disability law in schools are magnified in the juvenile justice system, where there is little understanding of disabilities or disability law and where few resources exist to adequately address the needs of youth with disabilities.
- Most sources suggest that many schools are not providing legally required services to youth with disabilities. The needs/services gap appears to be even greater in the juvenile justice system, where the primary focus is on sanctioning youth for their delinquent behavior, not on providing services. Systematic, empirical documentation of these gaps does not currently exist or is not readily available.
- There are many opportunities for improving both research and practice. However, the existence of such opportunities by themselves is insufficient to result in a change in the levels and quality of programming and enforcement of juvenile justice and disability law.
- Some research and anecdotal evidence suggests that as schools have become more restrictive and punitive (e.g., zero tolerance approaches to misbehavior), they have increasingly pushed greater numbers of youth with disabilities into the juvenile justice system. Many observers speculate that the failure of many schools to fully and

consistently implement federal law, especially the Individuals with Disabilities Education Act, has contributed to this process.

- Few local, state, or national organizations maintain consistent or reliable records of the types and levels of services or funding of programs that focus on youth with disabilities who are at risk of entering or involved in the juvenile justice system.
- Despite calls for significant prevention and early intervention efforts in schools and the juvenile justice system, there is little evidence that such efforts are widespread. The absence is notable because research suggests that such programming may be the only effective method for reducing the involvement of youth with disabilities in the juvenile justice system, especially in the "deeper end" of the system (e.g., correctional facilities).
- Racial/ethnic minorities, including Native American youth, are overrepresented at most stages of the juvenile justice system and among the population of youth with disabilities. Yet, there is little evidence that juvenile justice systems are providing appropriate disability-related programming for this population, or that they have developed culturally appropriate approaches for these youth.
- A range of increasingly popular intervention strategies and trends exists in schools and the juvenile justice system. Although some explicitly focus on youth with disabilities, many more diffusely focus on youth with behavioral problems. The more popular disability and delinquency intervention strategies and trends include positive behavioral support treatment; alternative education; diversion from the juvenile justice system; restorative justice; specialized youth courts; and greater intra- and interagency information-sharing.
- Researchers have not systematically identified and assessed interventions or practices that focus primarily on youth with disabilities who are at risk of delinquency or are involved in the juvenile justice system. As a result, there remains little scientific basis for recommending specific programs for these youth.

The major recommendations NCD makes are to

- Identify a range of strategies to enforce and promote compliance with federal disability law as it relates to children and youth with disabilities who are at-risk of delinquency. The strategies should include those that increase effective programming for youth with disabilities in schools and in juvenile justice settings.
- Increase funding and/or resources to schools and the juvenile justice system to ensure that youth with disabilities receive appropriate services.
- Designate a single federal agency whose sole focus is to ensure that the rights and needs of youth with disabilities entering or in the juvenile justice system are addressed. The Coordinating Council on Juvenile Justice and Delinquency Prevention and the President's Task Force on Disadvantaged Youth may be well-suited to provide the direction and leadership to address this gap by helping to create a national commission focused explicitly on youth with disabilities at risk of entering or already in the juvenile justice system.

- Conduct research that focuses on establishing the true prevalence of youth with disabilities of different types among at-risk populations in schools and across all stages of the juvenile justice system; the needs/services gap, including compliance with disability law; the causes of overrepresentation, where it exists, of youth with disabilities in the juvenile justice system, especially correctional facilities; and effective systems-level and program-level approaches, including federal laws, for addressing the needs of these youth, including particular attention to the types of programming most effective for youth from diverse racial/ethnic and cultural backgrounds.
- Undertake a comprehensive assessment to determine what programs and policies are most effective in schools, communities, and the juvenile justice system. At the same time, ensure that there is a balanced approach to funding diverse programs and policies, coupled with evaluation research studies of their effectiveness. Such an approach will ensure that a more definitive body of knowledge can develop to determine "what works" and for whom.

Conclusions

There is a tremendous gap in empirically based knowledge about children and youth with disabilities, especially those who are either at risk of delinquency or involved in the juvenile justice system. This gap covers a wide spectrum of largely unanswered questions involving distinct sets of policy issues. These issues range from the potentially conflicting philosophies underlying existing laws to what is known about effective prevention, intervention, and delinquency management strategies and efforts to ensure that the rights and needs of children and youth with disabilities are addressed.

The bulk of research on the children and youth of focus in this report—those with disabilities who are at risk of delinquency or involved in the juvenile justice system—provides a relatively weak foundation for drawing sound empirical generalizations. For example, one of the only relatively well-studied issues relating to this population is the prevalence of disabilities among incarcerated youth. NCD's research suggests that disabilities, especially learning disabilities and serious emotional disorders, are far more common among incarcerated youth than among youth in schools. Yet this research, too, suffers from inconsistent definitions and measurements. In addition, it provides a weak foundation for making generalizations about youth in other parts of the juvenile justice system, including probation, parole, and nonsecure residential treatment facilities. These problems are even more endemic in the other areas covered in this report.

This report has many implications for research and policies focused on children and youth with disabilities who are at risk of delinquency or justice system involvement or who are already involved in the juvenile justice system. The challenges are numerous, but in almost all instances the need for more and better research is clear. Which areas should be prioritized must ultimately be determined by policymakers and practitioners. Clearly, a more complete and accurate portrait of the kinds of disabilities present among youth referred to the juvenile justice system is needed. At the same time, research is needed on the extent to which youth with disabilities are having their needs addressed at all stages of the juvenile justice system. Research is needed as well on effective programming. Which areas require greater attention can be determined only by the priorities of specific stakeholders (e.g., schools, probation departments, correctional facilities, communities). However, advances in knowledge in any of these areas likely will contribute to a

greater ability to decrease delinquency among children and youth with disabilities, to ensure that the needs of these children and youth are effectively addressed, and to enhance positive physical, mental, educational, and other life outcomes among this population.

[Note: The report is available at http://www.ncd.gov/newsroom/publications/2003/juvenile.htm]

National Council on Disability

1331 F Street, NW, Suite 850

Washington, DC 20004

202-272-2004 Voice

202-272-2074 TTY

Statement by Edward J. Loughran, executive director, Council of Juvenile Correctional Administrators (CJCA) to be included for the record in the July 7, 2004 hearing: "Juvenile Detention Centers: Are They Warehousing Children with Mental Illness."

The incarceration of youths with mental health problems in correctional facilities has been an increasing problem over the last five years. As executive director of the Council of Juvenile Correctional Administrators (CJCA) I offer testimony on behalf of the juvenile chief executive officers in each state who have struggled with the reliance on corrections as the last resort, or only resort, for these youths. I would like to add support for improving the access to mental health services for youths outside the juvenile justice system as well as increasing federal involvement and understanding of the mental health needs of the youths currently in contact with the system.

No family should have to give up custody of a child in order to access mental health treatment nor should a youth with mental health problems be placed in a facility or program designed to rehabilitate law-breaking youths. Yet the prevalence of mental disorder among youths in the juvenile justice system is two-to-three times higher than among youths in the general population – approximately one out of five have a serious mental disorder and anywhere from 70 to 100 percent have a diagnosable mental disorder. Of the nearly 1.7 million delinquency cases processed in courts across the country in 1999, about one-quarter of them result in placement in a residential facility, outside the home. As researchers continue to collect data the practitioners see the problem each day: youths with mental health problems that are not identified, treated and linked with community services end up in locked facilities.

CJCA leads two national initiatives to better address the problem of youths with mental health problems in the juvenile justice system. Both focus on:

- First, identifying the youths so that decisions regarding placement, services and sanctions are made with the knowledge of the youth's needs, and
- Second, once identified, unless there is a real threat to public safety, the youths should be diverted from the juvenile justice system to an appropriate mental health service provider.

One initiative, launched by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs, US Department of Justice, is to develop a model for identification, diversion and delivery of services for youths in contact with the juvenile justice system. The model, to be completed and presented for implementation by the end of 2004, looks at the points in the case processing of youths, such as first contact with police, intake, detention, court processing, placement and aftercare and identifies appropriate interventions, evidence-based services and alternatives to incarceration.

The second, the Comprehensive System Change Initiative (CSCI) funded by the John D. and Catherine T. MacArthur Foundation as part of the National Center for Mental Health and Juvenile Justice (NCMHJJ), works with individual jurisdictions to create a coordinated service system for children and youths that accesses mental health services, child welfare and juvenile justice as appropriate.

There are increasing screening and assessment tools available to identify youths with mental health problems, most notably the MAYSI – 2, which is used currently in 45 states to quickly identify youths at various points in the juvenile justice system. The V-DISC, a computer-operated, voice-activated diagnostic assessment tool is being used in 15 states.

Diversion options, such as the evidence-based Multisystemic Therapy (MST) and Functional Family Therapy (FFT) have shown positive results and are increasingly being used across the country. There are models of blended funding and using Medicaid to structure alternatives to detention that could be replicated.

Despite the bleak picture, there are initiatives, research and system change efforts that need support. I urge the Governmental Affairs Committee to continue its work to bring agencies together to develop a coordinated system of care for youths. Please count on CJCA as a resource and partner in that effort.

Thank you for the opportunity to testify.

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